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MEDICAL EDUCATION ISSUE

Medical Education and Patient Care
Wilburt C. Davison

Medical Schools in Florida
Deans — Programs

Making Doctors — An Editorial

A.M.A. CLINICAL SESSION
MIAMI, NOV. 29 - DEC. 2, 1954

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(1) Kirby, W. M. M.; Waddington, W. S., & Doornink, G. M.: Antibiotics Annual, 1953-1954, New York, Medical Encyclopedia, Inc., 1953, p. 285.
(2) Finland, M., & Haight, T. H.: *Arch. Int. Med.* **91**:143, 1953.

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Changes in Medical Education and Patient Care

WILBURT C. DAVISON, M.D.
DURHAM, N. C.

Money, both private and public, has been responsible in the past for the progressive changes which have occurred in American medical education and patient care. Now, unless more funds, both private and public, are obtained, and obtained quickly, this progress cannot be maintained. The previous advances can be divided into four epochs:

I. Lecture Mills

The proprietary, lecture mill or pre-Hopkins or pre-Harvard era began in 1765, when the first North American medical school was started by John Morgan (although the Faculdad de Medicina in Mexico was founded in 1578, and that of the Universitad de Lima, Peru, in 1638).[1] The first North American M.D. degree was granted by King's (now Columbia) College in 1770, and the first Ph.D. degree by Yale in 1861. This epoch ended in 1893, the entrance date of the first Johns Hopkins class.[2] In the eighteenth and for a greater part of the nineteenth century, except for the few Northerners who went to Scotland on their own initiative for a medical education, and the Southerners who were sent to France by wealthy planters in order to give their slaves good medical care,[3] most of the American doctors received their training by apprenticeships. Physicians soon found, however, that it was financially profitable, from the students' fees, as well as from the income from the increased practice attracted by a medical school professor, to organize commercial proprietary medical schools, and by 1893, 160 of them had sprung up in various parts of the country. Some of them had nominal connections with universities, as at Pennsylvania, Harvard, Virginia, Transylvania and Florida,[4] but in general they were organized to make money for the faculty, and with little or no thought given to medical education. Courses at most of these lecture mills were limited to two sessions of three or four months each, there was no division into grades, and the pupils sat through the same curriculum twice over, on the theory that what they had missed the first time they might understand the second.[5] Hospital and laboratory work was almost unknown.[4] It is true that "there were giants in the earth in those days,"[6] such as Cabell, Drake, Holmes, Howland, Long, Matas, McDowell, Nott, Osler, Reed, Sims, and Welch,[7] but there were far too many Lilliputians, and the United States was ripe for the next era.

II. Ward Teaching

The transition, ward or pre-Flexner epoch lasted from 1893 to 1910 when the Flexner report to the American Medical Association[8] purged the proprietary schools. This era, like its proprietary predecessor, was based on money, though from a different point of view. Johns Hopkins' will in 1878 provided $7,000,000 to build and endow a university, hospital and medical school, an enormous sum for those days before inflation. The trustees and John Shaw Billings studied and prof-

From the Department of Pediatrics, Duke University School of Medicine and Duke Hospital, Durham, N. C.; with the assistance of Dr. Alan M. Chesney, The Johns Hopkins University School of Medicine, Miss Judith Farrar, Assistant Professor of Medical Literature, Duke University School of Medicine, and Mrs. Anne Tipner, Secretary to the Secretary of the Council on Medical Education and Hospitals of the American Medical Association, to whom great thanks are due.

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ited from the renaissance of university medical education in Germany, which had been financed by the indemnity collected from the French after the Franco-Prussian War (again money),[9] and opened the first "modern" American hospital and medical school in 1889 and 1893 respectively.[10] The Hopkins contribution in 1893 was fivefold: (1) assembling an outstanding faculty of four young men, consisting of Osler, Welch, Halsted and Kelly (their average age was 35 years); (2) the requirement of a college degree for admission; (3) the first four-year medical curriculum; (4) the introduction of students into the wards and laboratories (Osler "desired no other epitaph, than the statement that I taught medical students in the wards");[2] and (5) last but probably more important than any other factor responsible for the elevation of medical education, the rigid selection of students. The selection of medical students with emphasis on character, as well as preparation, is, or should be, one of the most important tasks of a medical faculty. A good student will become a good physician regardless of the instruction he receives, while a mediocre one rarely does.[11]

Up to 1893, any untrained lad was allowed to study medicine anywhere in America, and although John Morgan in 1765[12] and Daniel Drake in 1820 had recommended a broad premedical education, these entrance requirements were thrown into the dump heap whence they were salvaged with great éclat by the founders of the Johns Hopkins University.[5]

For the first few years, the Hopkins faculty wondered whether the baccalaureate entrance requirement and the four-year curriculum would deter students from applying; in fact, most of the original faculty admitted that they themselves could not have fulfilled the admission requirements.[2] The classes, however, were soon filled, and other university schools, including Harvard,[13] followed this pattern.

During this era, efforts were made to design the medical schools and hospitals so that the diseases and the normal and abnormal functions of the patients could be studied and taught in the wards and laboratories. The curricula were revamped and lengthened, and the entrance requirements raised so that the last high school student to enter directly into medical school did so in 1910. Most of the schools soon required one to three years of premedical college work for admission, and a few of them, like the Hopkins and Cornell insisted on a degree. By 1908, there were three classes of medical schools, good, bad and indifferent, and the Council on Medical Education of the American Medical Association, with funds from the Carnegie Foundation and with the cooperation of the Association of American Medical Colleges, authorized Nathan P. Colwell and Abraham Flexner to inspect all of the schools. The Flexner report[8] classified 148 of the 160 schools as A, B and C, and the State Boards of Medical Licensure, which had arisen in the 1880's and 1890's, were asked to license only the graduates of the 66 Class A schools. By 1910 when the report was published, the total number of schools had dropped to 95.

Nursing education is in this transition stage at present, but is awaiting a modern Florence Nightingale to follow Osler's example, namely, to lead the nurses back from the lecture halls to the patients. The best care of the patient is the best training for students of nursing, as well as for those in medicine.[14] Nursing and medical teachers should follow paths which converge on the patient, instead of diverging, both in nursing and medical education, to the classroom and laboratory.[15]

III. Laboratory Emphasis

The scientific or laboratory era spanned the four decades from 1910 to 1950, the age of "wonder and miracle drugs."[16] Again, money had produced changes in medical education and patient care. During this period, the munificent gifts of the Rockefeller Foundation with Abraham Flexner, Richard M. Pearce Jr., and Alan Gregg as Directors, the Carnegie Foundation, Commonwealth Fund, George Eastman, James B. Duke, John and Mary R. Markle Foundation, National Institutes of Health of the United States Public Health Service of the Department of Health, Education and Welfare, National Foundation for Infantile Paralysis, National Tuberculosis Association, American Cancer Society, American Heart Society, Army, Navy, Air Force, and Veterans Administration, to mention only a few sources of funds, enabled the Hopkins, Washington, Iowa, Rochester, Vanderbilt, Harvard, Duke and other universities to establish "strictly" full-time or "geographic" full-time departments.[17] Appropriations to state-supported schools also were greatly increased. This era has been called the golden epoch in American Medicine.[18]

Although similar progress was made in other medical fields, pediatrics is an excellent illustration of these changes. For example, John Howland at the Hopkins in 1912 to 1926 established pediatrics on a university full-time level, and his 30 disciples became heads of pediatric departments in medical schools in the United States, England, Hungary and Japan.[19] Pediatrics became simplified,[20] and preventive measures soon shifted the emphasis from the need of caring for sick children to the more important problem of keeping them in sound physical and mental health.[21]

During the flowering of this scientific era, the medical school curricula expanded into biochemistry, mycology, virology, enzymology, vitamins, nutrition and chemotherapy (two thirds of the drugs now used were unknown 10 years ago).[22] The introduction of these "wonder and miracle drugs"[16] has led to the administration of sulfonamides, penicillin, streptomycin, Aureomycin, Terramycin, ACTH, cortisone, Chloromycetin, and others, for several days (sometimes together, but usually in succession) without examining the patient, and then trying to diagnose when the treatment is unsuccessful. Instructors should realize that, regardless of arguments to the contrary, this practice will be continued as it usually is effective and rarely does harm. What is the use of clinics on pneumonia if patients are cured before the physical and roentgenologic signs can be demonstrated? Though appalling from the point of view of the teaching of medicine, this trend has simplified its practice and has led to the end of the "scientific era."

IV. Ambulatory Patient Care

The humanitarian or outpatient or ambulatory patient epoch started about 1950 with an effort to focus the attention of medical students and the profession on the patient, not solely as the site of a disease but as a human being and as a member of his family and community with many other problems in addition to his illness, which require advice and adjustment.[23,24] This new concept is a symptom of the growing discontent with medical education and the numerous attempts to improve it, which are the greatest assets of American medical education, and are in marked contrast to the German self satisfaction.[25] American and German medical education were on a par after the Flexner purge of 1910-1915,[8] but Americans have gone ahead while the Germans not only failed to keep pace with modern medicine, but have slid backwards. Their situation should be a constant reminder to us not to let our pride in our achievements prevent us from trying to climb higher.[26] Fortunately, the Commonwealth Fund has financed a curriculum study at Western Reserve Medical School, and other experiments are under way at some of the other schools.

During this past generation from 1910 to 1950, diseases were studied and methods to prevent and cure some of them were found, but the patient as a whole was often disregarded. The focus now should be on rediscovering the patient, his nature and behavior as an individual. The greatest need of the present era is for a professor of ambulant medicine who can correlate the patient's clinic and hospital diagnosis and treatment with his total care, and thus maintain his physical and mental health. More instruction is needed in medicine, pediatrics and psychiatry, and less in anatomy and surgery. The medical schools no longer train "physicians and surgeons;" so surgery should be a postgraduate subject. Yet in some medical schools, 25 per cent of the available hours are still assigned to anatomy and another 25 per cent to surgery and the surgical specialties.

The present day approach to medical education must be based upon a new concept of preventive medicine, an awareness of the role of the doctor in society, the realization of the true nature of the patient-physician relationship and the necessity for continuity and integration in patient care. The physician must be prepared to assume the leadership in the community in health matters and to furnish expert and unselfish advice in order to aid in the solution of these problems. This concept that the physician is responsible for the health of his patients, rather than only for their illnesses, calls for an active indoctrination of the student into a "comprehensive" type of medicine which evaluates the social and emotional components as they bear upon health and disease. Provision must be made in the medical schools to allow the students to learn and *practice* total continuity of patient care, through participation in medical care in the home,[23, 24, 27, 28] or by preceptorships with qualified general practitioners. The latter type of training has been offered at Duke since its opening in 1930.[29] F. W. S. Brimblecombe's scheme for the Home

Care of Sick Children by the staff of St. Mary's Hospital, London, will do for the masses what is occasionally done only for the privileged few. It would be of great psychologic benefit to the patients as well as a financial saving to their families and the hospital. Many educators forget that a similar program was started in Boston in 1875,[27] and was used by Osler at the Johns Hopkins in 1895, as well as at Syracuse, Georgia and other medical schools,[28] and that some of this training was formerly provided by the now abandoned "outside obstetrics." The faculties of the medical schools must be expanded in order to include in the everyday work-up of patients by the students, the concepts which can be furnished by psychodynamically oriented psychiatrists, highly qualified social workers, psychologists, sociologists, biometricians, statisticians, and others.[30]

This transition from teaching disease in hospital wards to the total care of ambulatory patients has been hastened, if not made necessary, by the almost universal and usually successful sulfonamide and antibiotic ambulant therapy, as well as by preventive measures, which have greatly reduced the frequency of many hospital conditions, which were common in 1930,[31] so that now the outpatient clinic has become, by far, the more important teaching service.[21] Eventually, hospitals should be empty, except for neonates, prematures, the ill children of working mothers, accident patients, those subjected to unpreventable surgical operations, obstetric patients and those presenting difficult medical, pediatric and psychiatric problems. More space, a larger percentage of the teaching hours, and the best instructors are needed for the outpatient instruction of medical and nursing students. Each member of the senior staff should work in the outpatient clinic at least one afternoon per week in order to know the students on a less formal basis. Furthermore, the senior faculty by working in the outpatient clinic, can rediscover with the students the humanitarian approach to medicine. The preceptorial program in which senior students spend two weeks with a philosophic practitioner of medicine has helped to fill this need.[29]

Keeping patients out of hospitals and treating them in a physician's office or outpatient clinic not only is a great psychologic benefit, but the financial saving is enormous, regardless of whether the patients, parents, taxpayers or university endowments pay the bill. For example, the actual daily cost of a Duke Hospital bed is $19.57, while the average office or outpatient visit charge is $5. Most patients cannot afford hospital costs, but they usually can pay physicians' or clinic fees.

During and after the second war, medicine learned teamwork with the paramedical group, the doctor acting as captain but only as one member of the team in providing patient care. For every 27 hours of care received by the average patient, only one hour (3.7 per cent) is performed by physicians, a large portion being given, and most efficiently given, by nurses, social workers, technicians, psychologists, sociologists, and others.[32, 33] The field of preventive psychiatry and psychosomatic medicine requires that physicians and ancillary groups must work together, and the ideal place is in the outpatient clinic or physician's office.

This new concept of medical education is a complete reversal of Osler's emphasis on ward teaching[2] and of Francis W. Peabody's statement that the general ward was the backbone of the clinic.[34] The new buildings at Michigan, Duke and some other schools indicate the belief that the outpatient clinic is not only the backbone but also the soul of the clinic. By analogy to automobiles, this new goal is the operation of a service station to keep the patient well and happy, rather than to run a repair shop.

Medical Progress

Medical progress can be continued and its humanitarian goals attained if the schools and profession will face and solve the 10 problems listed. The greatest present obstacle to their solution is the need for money for faculty salaries, operating expenses, increased working space and other facilities. The higher financial rewards of private practice and of commercial laboratories are largely responsible for the difficulty in recruiting personnel for the medical school faculties, as well as for the Army, Navy, Air Force, Veterans Administration and Atomic Energy Commission.

1. — CURRICULUM: In spite of the protests of students and teachers, the *accelerated schedule* has demonstrated its value. It is right in principle and advantageous in practice. Seventy-six per cent of the Duke students are graduated in less than four calendar years on the voluntary accelerated program, which is now in its twenty-

fourth year.[17] A year can be saved by condensing the four medical school years of 33 weeks into three years of 44 weeks each. The advantages to the medical student are obvious. He will be one year younger at graduation and will have an additional year for hospital or other training; he will be better prepared, for he will not have lost a fortnight or a month in October of each year getting back into the intellectual stride which had been his in the preceding June, and he will see the clinical material peculiar to the summer months.[35, 36] In addition to these benefits to the students, the utilization of the buildings and laboratories for a full calendar year instead of the usual academic eight months will enable the schools to admit one third more students if funds can be obtained to employ as medical teachers the hundreds of young graduates who at present are working on outside research grants.

2. — Premedical Education: There is also need for overhauling premedical education.[37] The time has come when the medical schools should consider the inclusion of premedical courses in their curricula similarly to the Canadian, British, Danish and Swedish programs.[38] Ours is the only country in which the medical schools do not supervise premedical education.[26] The universities and medical schools should have a cooperative program[39, 40] to which the students would be admitted directly from high school to study English, mathematics, chemistry, physics, and biology and social studies for the first two years with advancement to the medical courses at the end of their sophomore year only if they give promise of being a credit to themselves and their universities. In this way, one or two years of the present three to four years premedical preparation could be saved, and its quality would be better than is usually furnished by many of the colleges and universities, whose instructors tend to cram masses of facts and information into students without much emphasis on their understanding the subject itself or on the application or the integration of the material. Factual content assumes a position of paramount importance to the exclusion of knowledge, wisdom or philosophy. It is far more important for a student to have a clear idea of the subject than it is to be befuddled by too much information about it. More emphasis should be placed on the significance and meaning of data rather than on their accumulation.[41]

It has often appeared to the Duke faculty that some of the difficulties and resistances which have been encountered in teaching psychiatry and comprehensive medicine to medical students might in part be due to their lack of training in or understanding of the evolution of society and of medicine's place in it. As far as can be ascertained, orientation in these matters is nonexistent in the colleges. Would it not prove profitable to study the relationship of medicine to society (past and present), to correlate existing information on the subject and so to furnish material which might be used in sociology courses for premedical students in colleges? In this type of course, the student might obtain a clearer understanding of his role as a physician.[30]

Another variation of this integrated premedical and medical program is the selection of top-flight premedical students at the end of their freshman year, as suggested by Conant,[40] and guaranteeing them admission at the end of their sophomore or junior year on the sole condition that they complete the entrance requirements and maintain the qualifications which led to their original selection. Duke is following this plan as a limited experiment to enable premedical students accepted at the end of their sophomore year to obtain a good education rather than the usual collection of semester hours which are now necessary in order to meet the various and bizarre entrance requirements of the several medical schools to which most students apply in their last year of college. If it is successful, the plan will be expanded. It is realized that this program may be criticized for accepting students before they have been properly appraised. The same charge, however, was made against the Johns Hopkins when that school admitted students 12 months before the medical class started, instead of three months as all schools practiced until 1925.[11] Now every school admits its candidates six to 12 months before the medical class starts.

3. — Financing of Medical Students: Probably the best way by which a sufficient number of students can attend medical school is through interest-bearing loan funds, which can be repaid over a period of years, and thus become available for future students. The usual scholarships require too great an outlay.[42] Loan funds to students who have agreed to practice in the country or to intern in rural hospitals have been helpful.[43] The proposed Army, Navy, Air Force

and Public Health scholarships for medical students who plan careers in these services are mutually advantageous. Physicians entering the federal services should be financed similarly to West Point and Annapolis line officers.

4. — MEETING THE MOUNTING COST OF MEDICAL EDUCATION: The approach probably should be to request the communities for reimbursement of the medical schools for their professional services to indigent patients.[44] The state and counties in North Carolina and some other states have now accepted responsibility for paying for hospital care and have saved Duke University an annual average of a quarter of a million dollars. If the state and counties would also contribute only one dollar per outpatient visit and a dollar per day for the professional care of the public ward (not private) patients, they would relieve the pressure on the Duke Medical School annual budget by an additional $250,000. Hospital costs, patients' bills, and medical school subsidies also can be reduced by not admitting any patient who can and should be treated in the outpatient service.[45] The money raised by medical alumni, the American Medical Education Foundation, the National Fund for Medical Education, and payments to Duke by Florida also are of inestimable help.

5. — FINANCING THE PATIENT: Experimentation in the distribution of medical service has been taking place for many years throughout the United States, starting in Virginia in 1773, with the provision of institutions for the insane, followed in 1798 and 1820, respectively, by the Marine and Naval Hospitals for sailors. The former was supported by taxes and the latter by a wage deduction like modern Blue Cross Hospital Associations. The problem now is how rapidly the proportion between public-supported and private medicine should be changed. The Blue Cross and the Blue Shield Associations for those who are self-supporting, and county, state and federal funds for the indigent seem to be the logical answer. The danger is great that if the federal or state governments take over medical practice, they will not provide good medical care but only cheap service.[46] Our greatest need is for a prepayment plan to provide ambulant office and clinic diagnostic and laboratory service.

6. — THE "DEMAND" FOR MORE PHYSICIANS: Especially in general practice and particularly in rural areas, the "demand" for more physicians is acute,[47] in spite of statements that the public does not *"need"* them.[48] Technically, the opponents of more graduates may be correct in saying that the public and federal services do not need more physicians. It depends on one's definition of need. Joe Doake may not *need* a new automobile whenever he buys one, but he would resent anyone denying him one if he *demanded* it and could pay for it. The public as well as the federal services feel the same way about more physicians and wider medical service, and should have it if they are willing through personal, foundation, state and federal funds to finance the expansion of the medical schools. Statistics showing that the United States has more physicians per population than most other countries and that our medical care is the best in the world[48] do not convince Joe Doake, either as a civilian patient, farmer, union worker or wounded soldier, when he wants a doctor in a hurry. As a matter of fact, these or any statistics, as everyone knows, are misleading.[48] From 1940 to 1950, the growth of the population and that of the medical profession were the same (15 per cent); so their 1940 and 1950 ratios are identical. The federal services, industry, and other groups, however, have absorbed so many physicians that the actual increase of those in practice was only 5 per cent, thereby creating a deficit of 10 per cent in the ratio of practicing physicians to the population. Even worse is the situation in regard to general practitioners, for their numbers have decreased 13 per cent from 1940 to 1950 in contrast to the 15 per cent increase in population, leaving the public with a net decrease of 28 per cent in available family doctors.[36] Furthermore, the increasing age of the remaining general practitioners has greatly intensified the need* for more recruits in this field.[49]

In spite of the program to educate the public that better medical care, especially for the seriously ill, can be provided by transporting the patients to a hospital or clinic, and that this trip gives them not only the advantage of modern facilities for diagnosis and treatment but also medical service in a shorter time than usually is required to summon a local physician, all of which is true, many patients still prefer having their pulses taken at the bedside at home. The existence of these public beliefs, and of an increas-

*Of the 435 recent community requests to Duke for physicians, the majority were for genefal practitioners, a few for pediatricians, internists and otolaryngologists, but none for general surgeons.

ing *"demand"* for more medical services must be recognized and met.[50] Giving the public more physicians and a wider distribution of medical service is the surest way of avoiding state medicine.[46, 50]

7. — Overspecialization: Starting after the first war and fostered by the GI Bill of Rights of the second war, overspecialization has now become a menace to the wider distribution of medical service and a potent deterrent to graduates from entering general practice.[51] The prestige of the specialty boards, and the increased rank and pay by the governmental services and the limitation of hospital privileges to board-certified physicians have been too alluring. These boards were started in order to protect the public against unwarranted claims by ill-qualified specialists, but like the monster built by Frankenstein, or the tail that wagged the dog, the specialty boards are now dominating medical practice and are even trying to dictate to the medical schools the subjects to be included in the curriculum and the emphasis thereon. Each year, it is hoped that the specialty fields will be saturated, and only in the past year has there been such slackening.

8. — General Practice: The question, "Is the general practitioner doomed or is the profession overspecialized?" is easily answered. A well trained general practitioner can and does treat successfully 85 per cent of disease, and as his volume enables him to treat his patients at a lower cost, the public needs and wants more general practitioners. The fact that only 25 to 40 per cent of the present American medical graduates are or plan to be general practitioners, who are needed by 85 per cent of the patients, not only means that the specialities may soon be overcrowded (though that may be wishful thinking), but also indicates the urgent need and wide open opportunities for family physicians.[49, 52, 53] Furthermore, this plethora of specialists has caused such competition and crowding that in many communities the financial rewards of general practitioners, with their reduced competition, are higher than those of specialists. The American Academy of General Practice is helping to recruit prospective general practitioners and has raised their morale and increased their privileges and dignity. Demonstrating the advantages of general practice in groups, rather than group practice, may help recruitment.[53]

The medical schools and teaching hospitals, as well as the specialty boards, also are responsible for this drift away from general practice by too much emphasis on medical rarities and "straight" internships. More teaching on the common conditions and problems in the outpatient service, and better rotating internships of one or two years' duration with emphasis on medicine, psychiatry and pediatrics are needed. Experience has shown that if rotating and straight internships are given in the same hospital, the former are neglected, discouraged and sabotaged by the teaching and resident staff. The recent recommendation by the American Medical Association that straight internships should be restricted has been helpful in orienting medical students and staff to the importance of having all graduates take rotating internships before embarking on a specialty residency. Whatever the cause, the percentage of medical students who are applying for rotating internships and who are seriously considering general practice has markedly increased.

9. — Country Doctors: Surveys showed that 83 per cent of the Tennessee and 58 per cent of the Minnesota rural medical students returned to country practice and that only 20 and 22 per cent, respectively, of the city students settled in rural communities.[54] More country medical students, therefore, mean more rural practitioners. Unfortunately, there are entirely too few rural medical students. A recent national analysis of 6,011 first-year medical students revealed that only 12 listed an address on a rural route,[55] yet nearly half of our population is rural.[49] There are at least three reasons for this dearth of country medical students: (1) *Finances:* Because a city student has more sources for borrowing, several states have established loan funds and scholarships for students who agree to practice in the country.[43] (2) *Inadequate Country High Schools:* Usually country high schools do not provide an adequate foundation for college premedical courses so that a rural youth can compete successfully for admission to medical school with the students from the private preparatory schools or the better city high schools.[56] The fact that the percentage of rural medical students at Duke has risen from 4 in 1940 to 20 in 1953[57] is an indication that the country high schools have improved. Funds are now being sought, so far

unsuccessfully, to provide a tutoring program at Duke during the summer vacations in order to give carefully selected rural high school students, who wish to study medicine, a more adequate preparation for premedical college work.[56] (3) *Hospital Availability:* Another weighty factor in attracting recent graduates to practice is the availability of hospitals. The young, highly trained physician of today does not feel that he can practice modern medicine without access to a hospital. The hospitals in North and South Carolina assisted by the Duke Endowment, and those built under the Hill-Burton Act, have filled this need.

10. — RESEARCH: In some schools, the large research grants instead of aiding medical education have had the opposite effect.[58] Obviously, research is necessary for good medical education in order to stimulate the staff and students[26] and to make the patients feel that the latest discoveries are available to them, as well as to advance medicine, but equally obviously there is a point at which the research is of more value to medicine in general and to society than to medical education.[44] One of the causes for the decline of prewar German medical education was the overemphasis on research, and the siphoning of the best brains away from the medical schools, and segregating them into the Kaiser Wilhelm Institutes.[25] The present huge research grants may convert some of the American medical schools into similar research institutes. The dangers of overbalanced research in medical schools should be emphasized, and faculties should remember that: (1) the primary reason for a medical school is the instruction of undergraduate and graduate medical students at the highest level of standards,[13] (2) instructors should be selected on the basis of their teaching ability rather than on their prolific writing,[59] (3) research is essential to sound medical education, (4) too much research by medical school faculties may kill the goose which laid the golden eggs (assuming, of course, that well taught physicians are golden eggs), and (5) the pressure to produce papers will reduce the quality of research and give the investigator an erroneous idea of the relative value and balance of research and teaching. Medical schools need more first-rate clinicians like Osler and Peabody, who are oriented to this new concept of ambulatory medicine, instead of the present plethora of young Pasteurs.[15]

Summary

North American medical education can be divided into four eras or periods: lecture mills (1765-1893), ward teaching (1893-1910), laboratory emphasis (1910-1950), and outpatient or ambulatory patient care (1950-).

During the present epoch, the attention of students and faculty is or should be focused on the patient, not solely as the site of a disease, but as a human being and as a member of his family and community with many other problems in addition to his illness which require advice and adjustment.

More outpatient teaching, home visits and preceptorial experience with general practitioners are needed to make the students and staff cognizant of the family, community and environmental relationships of medicine.

Premedical and medical education should be integrated and an accelerated curriculum used.

More loan funds are needed for medical students.

In order to maintain the present standards, more money is needed for medical faculty salaries, operating expenses, increased working space and other facilities.

States and counties should reimburse the medical schools for their professional care of indigent patients.

State and federal funds should adequately finance the expansion of medical schools to meet the demand for more physicians, especially for rural general practitioners.

Research is a necessity for sound medical education, but should be coordinated with teaching and not submerge it, and instructors should be appointed on the basis of their teaching ability rather than solely on their prolific writing.

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Functioning Ovarian Tumors

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The term "function" as applied to a neoplasm may reflect certain histologic alterations, such as the production of bile or mucus by tumor cells. It may apply equally to the elaboration of hormones or other substances that, on gaining entrance to the circulation, effect physiologic alterations in the host. In some instances the pathologist and the physiologist may be able to correlate their findings, whereas in others such correlations may be impossible.

Tumors of ductless glands furnish the best examples of functioning neoplasms, and those of the ovary exhibit the widest range of variability in this regard. Six types of ovarian tumors are the subject of this presentation; 3 are feminizing, 2 are masculinizing and 1 is "neutralizing." In addition, mention will be made of struma ovarii.

Granulosa Cell Tumor

DEFINITION. — Granulosa cell tumor is a functioning, feminizing ovarian tumor comprised of cells resembling in appearance and arrangement the elements of the normal membrana granulosa and, like it, capable of elaborating estrogen.

HISTOGENESIS. — These tumors can be produced experimentally by irradiating the ovaries of immature female mice; it is thought that they arise from the mesenchymal stroma of the ovary rather than from pre-existing membrana granulosa or from the germinal epithelium. These tumors also develop in castrated female rats when bits of their ovaries are transplanted into the spleen. Estrogen elaborated by these grafts is destroyed by the liver before it reaches the general circulation. Development of granulosa cell tumors from such grafts is explained by some investigators on the basis of an unopposed action of pituitary gonadotropin.

INCIDENCE. — Granulosa cell tumors comprise from 2 to 3 per cent of any sizable series of ovarian tumors; about 700 cases have been reported in the literature. Ten per cent of the patients who have such tumors are children, 40 per cent are between puberty and the menopause, and the remainder are older.

SYMPTOMS. — Granulosa cell tumors occurring during preadolescent years induce sexual and somatic precocity with premature onset of vaginal bleeding that, while anovulatory, may be profuse and semiperiodic. Amenorrhea is seen in 50 per cent of sexually mature women having such tumors, and it may reflect a high level of circulating estrogen produced by the lesion. Other patients may bleed irregularly. Infertility is an almost constant feature since ovulation from the sound ovary is hormonally suppressed. Semiperiodic menstrual-like bleeding is the rule in postmenopausal women. Tenderness of the breast may be present.

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Diagnosis. — When the afore-mentioned symptoms are manifest, all but the smaller causative ovarian tumors will be palpable. The concomitant finding of a large uterus is confirmatory evidence.

Laboratory studies of assistance include the demonstration of excessive quantities of urinary estrogen. Bio-assays of tumor tissue may show the presence of this substance. A decrease in the level of circulating estrogen will be manifest by uterine bleeding within 24 hours of operation in those patients in whom the ovarian tumors have been treated by local extirpation.

Pathologic Features. — At operation, the tumors are sizable growths that may be solid or cystic. They are unilateral in 95 per cent of cases. Lobulation or encapsulation is the rule, but 20 per cent are malignant and are adherent to surrounding structures. This feature is seen more frequently among older patients. The enlarged uterus contains an independent, hormonally induced carcinoma in about 20 per cent of cases of granulosa cell tumors affecting women more than 50 years of age.

The microscopic features include a basic composition of small prismatic granulosa-like tumor cells disposed in rosettes, cords and irregular strands. Admixture with typical theca cells is frequently observed, and both granulosa and theca elements may exhibit areas of luteinization. Mitotic figures are generally infrequent except in the aggressive tumors observed chiefly in older patients. In other instances the dividing line between benign and malignant lesions can be appraised only through the "retrospectoscope" in analyses of cases after five and 10 years.

Treatment and Prognosis. — About 20 per cent of granulosa cell tumors recur and metastasize. Such spreading tendencies usually can be anticipated in connection with poorly encapsulated growths, especially in older patients. The use of conservative surgical procedures is indicated for young persons, whereas the employment of more radical measures for those more than 50 years of age appears logical. Pregnancy is possible after simple removal of a granulosa cell tumor in a young person. Endometrial carcinoma may be found at panhysterectomy for granulosa cell tumor in an older patient. The tumors themselves are radiosensitive, and use of radiotherapeutic procedures should be kept in mind to prevent recurrence from locally invasive tumors.

Theca Cell Tumor

Definition. — A theca cell tumor is a solid ovarian tumor composed of cells resembling those of the theca folliculi. Such a tumor occasionally produces enough estrogen to feminize its host.

Histogenesis. — Anatomic studies plus results of experimental production of these tumors by roentgen rays in immature female mice indicate an origin from the ovarian stromal mesenchyme. The frequent occurrence of combined granulosa and theca cell tumors in humans favors derivation from a common ancestral cell.

Incidence. — Approximately 125 examples of this tumor have been reported since its first description in 1932. The tumors are rarely seen in persons less than 30 years of age. Two thirds of the growths occur in the postmenopausal period.

Symptoms. — These are essentially the same as those described for granulosa cell tumor, but features of feminization are usually not so pronounced since theca cell tumors do not so regularly elaborate significant quantities of estrogen. In 20 per cent of cases the associated uterine bleeding results from estrogen-induced carcinoma of the endometrium.

Diagnosis. — Physical findings and results of laboratory studies in the average case are such that the correct preoperative diagnosis will not often be made.

Pathologic Features. — These unilateral tumors are most often diagnosed surgically as fatty fibromas because of their encapsulation and orange-yellow color. They are nearly all solid and average 5 to 10 cm. in diameter. The contralateral ovary is often atrophic because of estrogen-induced suppression of function. Nevertheless, the uterus is unusually "large and healthy" except for the frequent association of myomas. Cut surfaces of the tumor show a fibrous composition and a tan-yellow color.

Microscopically, a composition of fat-laden plump spindle cells arranged in bundles with intervening fibrous and hyaline bands is typical. In the absence, however, of occasional clusters of granulosa cells, the hallmark of a "mixed" tumor, differentiation from fibroma may be difficult. This diagnostic dilemma occasionally may be resolved by histochemical studies.

Treatment. — Although nearly all theca cell tumors are benign, their occurrence among older women and their frequent association with en-

dometrial carcinoma temper the need for conservatism. Removal of the uterus in these cases is good prophylaxis with regard to carcinoma.

Sertoli Cell Tumor

Perhaps the less said about these tumors the better, inasmuch as they are well established entities chiefly in the veterinary literature, in which they are best known as feminizing testicular tumors of dogs. The occurrence, however, of certain feminizing testicular growths in human males has led to a search for their homologous counterparts in human females. To many investigators, the tubular elements in arrhenoblastomas are estrogen-producing Sertoli cells; if it is correct, this observation provides a ready explanation as to why the more mature or differentiated arrhenoblastomas fail to masculinize as much as would be expected. It has been declared that the so-called tubular variant of granulosa cell tumor is actually a testicular Sertoli cell tumor of the ovary. Whether or not these intermediate tumors are actually Sertoli cell growths (androblastomas) remains to be seen. Meanwhile, it must be admitted that in certain cases the sexual pattern of the patient may be the reverse of that predicted as the result of microscopic evaluation of the tumor.

Arrhenoblastoma

DEFINITION. — Arrhenoblastoma is a defeminizing or masculinizing ovarian tumor that exhibits somewhere in its microscopic makeup a composition suggestive of testicular tissue.

HISTOGENESIS. — With the occurrence in the ovarian hilus of tubular structures accepted by many observers as being potentially, if not actually, testicular, an origin from these male-directed elements becomes a palatable theory. This notion is perhaps strengthened by the occurrence of arrhenoblastomas in ovotestes. Some of the tumors, however, exhibit nontesticular elements, and some investigators champion the idea of a teratomatous origin.

INCIDENCE. — Approximately 100 cases have been reported. For the most part, arrhenoblastomas affect women of child-bearing age.

SYMPTOMS. — These are typically those of defeminization and masculinization. Featured are amenorrhea with sterility, a masculine type of hairiness, atrophy of the breasts, hypertrophy of the clitoris and disturbing changes in the voice. Increased blood pressure, edema and plethoric obesity are usually absent. The causes of masculinization are legion, and by no means will every hairy woman seen in office practice have an arrhenoblastoma; however, the likelihood of this lesion in such a patient is heightened considerably by palpation of a solid pelvic adnexal tumor.

DIAGNOSIS. — Results of laboratory studies may reveal low values for urinary estrogen and elevated values for urinary ketosteroids. Not definitely essential in the diagnosis, these findings are the garnishments of a good case report.

PATHOLOGIC FEATURES. — These tumors are unilateral, moderate in size, semiencapsulated, solid and gray. They characteristically exhibit multicentric lobulation, like a cirrhotic liver. The uterus is smaller than normal and the contralateral ovary shrunken and atrophic.

The microscopic picture is variable, but in all instances one finds scattered clusters of pale, fat-filled cells resembling interstitial cells of the testis. (Certain ovarian hilar areas of proliferation seen in masculinized women are composed entirely of these interstitial cells; such areas scarcely deserve the designation of tumors, but they are mentioned for the sake of completeness.) The bulk of the arrhenoblastoma is, however, made up of other elements. In so-called differentiated lesions, tubules predominate. These are lined by columnar cells reminiscent of those seen lining the tubuli recti; they are not spermatogonial cells, and they contain droplets of fat. They have been interpreted by some workers as Sertoli cells. At the other end of the scale, the appearance, except for the afore-mentioned interstitial cells, is that of prismatic and spindle elements intermingled in a pattern practically indistinguishable from granulosa and theca cell tumors. It is these immature, or "undifferentiated," arrhenoblastomas that are the most active masculinizers. Definite teratomatous characteristics may be evident in some arrhenoblastomas.

TREATMENT. — The occurrence in young women and the gross encapsulation of the tumors, plus the disappearance of symptoms and the possibility of pregnancy after local removal, have been factors directing a policy of surgical conservatism in the treatment of arrhenoblastomas. Prolonged follow-up, however, reveals more than a 50 per cent chance for recurrence and metastasis, occurring five or even 10 years after operation. In view of these unfavorable late results, the additional sacrifice of the uterus, the tubes and the unin-

volved ovary would appear justifiable in many cases.

Masculinovoblastoma

Definition. — Masculinovoblastoma is a primary ovarian neoplasm that possesses the pathologic features of an adrenal cortical carcinoma and that produces the clinical picture of Cushing's syndrome.

Histogenesis. — To some, this neoplasm is explained most logically by means of growth of adrenal cortical rests in the ovarian hilus. Others regard the rest theory as redundant, since in adrenalectomized ground squirrels the ovarian stroma assumes the histologic appearance and physiologic function of adrenal cortex. A teratomatous derivation remains another unproved possibility.

Incidence. — Reports of about 20 authenticated cases comprise the literature on this rare type of ovarian neoplasm. Like arrhenoblastoma, masculinovoblastoma tends to affect women during the period of fertility.

Clinical Features. — To the masculinization that characterizes arrhenoblastoma, must be added plethoric obesity, hypertension, diabetes, polycythemia and other features of Cushing's syndrome. The finding of a solid tumor in a patient exhibiting these features enabled my colleagues and me, on one occasion, to make the correct preoperative diagnosis.

Results of laboratory and hormonal studies are characteristic of the pattern seen in adrenal cortical hyperplasia or tumor.

Pathologic Features. — The tumors are solid, thinly encapsulated, unilateral and of moderate size. They are distinctively orange-yellow in color, like theca cell tumors; unlike the latter, however, they are soft and friable, with a distinct tendency to develop zones of hemorrhage and necrosis.

A trabecular and alveolar grouping of large polygonal fat-filled cells at once suggests the picture of an adrenal rather than an ovarian tumor. Pleomorphism is pronounced and mitotic figures are numerous in the more malignant tumors. Glycogen may be demonstrated in the tumor cells.

Treatment. — Results in a small number of patients treated surgically and followed for five years indicate that the prognosis is good in spite of the fact that most of the lesions have been handled conservatively. It would appear, however, that infiltrative and cytologically active tumors of this type demand hysterectomy with bilateral salpingo-oophorectomy.

Dysgerminoma

Definition. — Dysgerminoma is an ovarian tumor that microscopically is identical to seminoma. It is the commonest tumor of the pseudohermaphroditic gonad. Because of this latter fact and the observation that otherwise normal women who have the neoplasm are frequently infertile, the growth has a weak claim to the caption of "neutralizing" tumor.

Histogenesis. — The point of origin of an exactly similar tumor, the afore-mentioned seminoma, has been traced in the dog to the spermatogonial elements of the testis. It has been found that embryonic male and female gonads both contain elements somewhat similar to the cells in dysgerminoma. Most investigators dismiss the matter of origin with the noncommittal statement that the tumors spring from neuter or dysgerminomal sex cells.

Incidence. — The approximately 300 case reports in the literature do not indicate the true incidence of this tumor, since many dysgerminomas removed surgically have been labeled atypical sarcomas of the ovary. Unlike seminoma, which affects middle-aged men, the majority of ovarian dysgerminomas occur in women who are less than 20 years of age.

Symptoms. — The early reported association of this tumor with clinical pseudohermaphroditism gave rise to misdirected concepts of a cause-and-effect relationship between the two conditions. Most of the tumors reported currently have occurred among otherwise normal women, including some who were pregnant at the time of the tumor's discovery. Like seminoma, dysgerminoma is likely to grow rapidly.

Pathologic Features. — Bilateral in almost a third of the cases, these tumors are generally large and solid; they are invested with a thin capsule. Their consistency is almost like that of brain tissue. Hemorrhage and necrosis are commonly seen on the cut surfaces. Growths that are bilateral or adherent are likely to prove fatal.

Histologically the picture features a monotony of large, round, hyperchromatic cells in a mosaic, with scattered sprinkling of lymphocytes. Mitotic figures are frequent in the large cells, and the

lesions are always highly malignant cytologically.

TREATMENT. — Surgeons in the past have been much more influenced by the body curves of the patients than by the mortality curves emerging from long-term follow-up studies in series of dysgerminomas. Reluctance to castrate has influenced surgical treatment, and a discouraging five year survival rate of 30 per cent has been the result. The tumors are radiosensitive, but here again reluctance invites delay in the institution of roentgen therapy until the onset of incurable recurrent lesions or independent neoplasia in the opposite ovary. Fortunately, with the present day availability of satisfactory replacement therapy with sexual hormones, more surgeons are gauging the treatment of dysgerminomas on the basis of their known malignant proclivities.

Struma Ovarii

Struma ovarii is an ovarian teratoma of thyroid tissue. Twenty per cent of ovarian teratomas contain thyroid tissue; in more than 120 reported cases, this element had overgrown to such an extent as to make the resulting tumor an ovarian goiter. In 5 per cent of these cases, clinical evidence of thyrotoxicosis was present, which sometimes led to unnecessary operations on the neck in an effort to prepare the patient for a major pelvic operation. Radioiodine in tracer doses is the current answer to these anomalous situations.

Pathologically, these tumors resemble nodular rather than exophthalmic goiters. Ascites is a frequent accompaniment, and malignant change is observed in 5 per cent of the lesions.

The Clinical Differentiation of Congenital Heart Lesions Amenable to Surgery

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MIAMI

Physicians can no longer be satisfied with a simple diagnosis of congenital heart disease. The impetus given to the surgical treatment of conditions of this type by Gross and Hubbard's patent ductus arteriosus ligation technic in 1939, and by the Blalock-Taussig shunt operation for tetralogy of Fallot in 1945, has made it imperative that we try to make an accurate diagnosis in each case, in order to identify those cardiac anomalies that can be benefited by surgery.

The new diagnostic aids, including cardiac catheterization and angiocardiography, have been invaluable in this direction. They have made it possible for us to understand the physiologic effects of most of the congenital cardiac defects. With this knowledge of hemodynamics, we should be able accurately to diagnose the type of lesion present in the great majority of cases with the aid of simple clinical methods, such as roentgenography, fluoroscopy, and electrocardiography, provided we make a thorough physical examination and study each patient from the functional point of view, correlating each sign or symptom observed with the dynamic processes that are likely to produce them.

It is the purpose of this report to review the diagnosis of those congenital heart lesions that are amenable to surgery at the present time. Let us, however, first briefly outline some of the important points to be looked for in the history and physical examination in cases of this type.

1. Dyspnea on effort is significant since the degree to which it is present is usually proportional to the severity of the lesion.

2. Cyanosis by its presence or absence enables us to limit the diagnostic possibilities in each particular case. Central cyanosis always implies a right-to-left shunt, such as in tetralogy of Fallot. In noncyanotic cases there is either a left-to-right shunt as in atrial septal defects and typical patent ductus arteriosus, or none as in coarctation of the aorta. The date of onset and persistence of cyanosis are important. We have all come across cases of atrial septal defect in which the child was cyanotic at birth and remained so only for two or three weeks; those of tetralogy of Fallot

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in which cyanosis was not detected until the child was about the age of two to three months; and those of Eisenmenger's complex in which cyanosis was not perceptible until later in life or when the patient had become an adult.

3. Clubbing of fingers and polycythemia usually accompany cyanosis.

4. Squatting is characteristic in cyanotic cases with diminished pulmonary flow.

5. Loud, rough systolic murmurs along the left sternal border are one of our most valuable clues to the existence of congenital heart conditions.

6. Dysphagia, stridor and frequent infections of the upper part of the respiratory tract form a triad which is a common finding in cases of aortic ring or anomalous right subclavian artery.

7. Headaches are frequent in cases in which cyanosis is present.

8. Syncope and angina are occasionally present in cases of isolated pulmonary stenosis or in those in which congenital heart lesions are associated with pulmonary hypertension.

The general development of the patient also may be of diagnostic assistance. Certain lesions, such as large atrial septal defects and patent ductus arteriosus, are associated with severe stunting of growth, whereas others, like isolated pulmonary stenosis, do not as a rule impair development.

Precordial bulge is usually associated with cardiac enlargement of considerable degree and is most commonly present in large atrial septal defects, large ventricular septal defects, or patent ductus arteriosus.

Examination of the heart should stress the following:

1. The point of maximal impulse must not be confused with the apex beat, although both may coincide. Normally, the point of maximal impulse is located at the fifth interspace just inside the midclavicular line. In left ventricular enlargement, the point of maximal impulse is coincident with the apex beat which is displaced downwards and outwards. In right ventricular hypertrophy, the point of maximal impulse is located at the third and fourth left interspaces near the sternum, and the apex beat is usually felt as a faint tap at the fourth or fifth interspace near the midclavicular line.

2. Thrills should be palpated for, and, of course, murmurs must be noted, also the points at which they are most intense and the direction of their transmission. Sometimes we may be in doubt as to whether a loud, rough systolic murmur, which is most intense at the second and third left interspaces near the sternum, is caused by a patent ductus arteriosus or a ventricular septal defect. It is worth while then to remember that patent ductus murmurs are usually transmitted upwards towards the clavicle, whereas ventricular septal defect murmurs are transmitted downward, along the left sternal border.

3. The second heart sound over the pulmonary area is significant. Is it accentuated, faint or absent, split or pure? A split pulmonary second sound signifies that both the aortic and pulmonary valves are present and functioning. In pulmonary stenosis, the second pulmonary sound is usually absent or faint; on occasion, however, it may be loud, but it is always pure. In atrial septal defect, it is widely split; in Eisenmenger's complex, it is especially loud and closely split.

Both radial and femoral pulses should be palpated. The absence of femoral pulses, especially in the presence of hypertension of the upper extremities, is almost pathognomonic of coarctation of the aorta.

Blood pressure should always be determined in the right arm, for it is known that there are cases of coarctation of the aorta, involving the left subclavian artery or just above it, in which there will be a normal or low pressure in the left arm. In suspected cases of patent ductus arteriosus versus ventricular septal defect, the blood pressure is sometimes especially helpful in differentiating the two conditions. In patent ductus, the pulse pressure usually tends to be wide; whereas in ventricular septal defect, it is normal or narrow.

On electrocardiographic examination, high, pointed P_2 is usually indicative of right atrial hypertrophy. Auriculoventricular blocks are common in septal defects, especially those of the atria. Right bundle branch block, complete or incomplete, is practically always present in capacity enlargement of the right ventricle, such as in atrial septal defects. Finally, the study of the unipolar chest leads will frequently be of even more help than roentgenograms in demonstrating whether there is left or right ventricular hypertrophy, or both.

Fluoroscopic and roentgen examination of the chest is also helpful for, in addition to determining which chambers of the heart are enlarged, we

should evaluate the condition of the lungs. Are they congested or clear? If congestion is present, does it extend out to the periphery, as in atrial septal defects, or only up to about the mesial third, as in ventricular septal defects? Are the pulmonary arteries prominent? Do they pulsate, and if so, to what degree? This should be noted especially in the branches of the secondary pulmonary arteries, where expansile pulsations are normally absent or just barely visible.

Let us now consider the more common congenital heart lesions that are amenable to surgery at the present time.

Coarctation of the Aorta

The development is usually normal. There may be no symptoms. Cyanosis is absent. Leg aches are a common complaint, and there may be headaches and dyspnea on effort, especially if there is hypertension of the upper extremities of considerable degree.

On physical examination, the point of maximal impulse is forceful and coincides with the apex beat, and there is usually a loud, rough systolic murmur along the left sternal border. The diagnosis is confirmed by the findings of a strong radial pulse and absent or weak femoral pulses, with blood pressure lower in the legs than in the arms.

The electrocardiogram shows left ventricular hypertrophy. On fluoroscopy, there is usually dilatation of the ascending aorta, and although the heart may not appear enlarged, careful examination will show concentric hypertrophy of the left ventricle. Occasionally, there is a second indentation on the left side of the barium-filled esophagus, just below the aortic arch, which is produced by a dilatation of the poststenotic segment of the coarcted aorta. Notching of the ribs is usually observed in adults.

Aortic Rings

The symptoms will depend on the degree of constriction of the trachea and esophagus by the ring. If this is severe, there will usually be stridor, dysphagia and frequent infections of the upper part of the respiratory tract.

On physical examination, the heart usually appears normal in size, and there may or may not be murmurs at the base. The diagnosis is made by roentgenograms and fluoroscopy, which show that both the right and left sides of the barium-filled esophagus are indented by the ring at the level of the aorta in the posteroanterior view, and also anteriorly and posteriorly at the same level in the right anterior oblique and lateral views.

Patent Ductus Arteriosus

The typical case is characterized by the absence of cyanosis, and there may be stunting of growth and slight to moderate dyspnea on effort. If associated with pulmonary hypertension, cyanosis may be present and will be more pronounced in the lower than in the upper extremities.

The cardiac findings are: (1) The point of maximal impulse forceful and heaving at the apex, which is displaced downwards and outwards; (2) a systolic or systolic and diastolic thrill at the pulmonic area; (3) a systolic impulse at the second left interspace; (4) P_2 split and accentuated, when heard; (5) in the typical case, a continuous, machinery-like systolic and diastolic rough murmur at the pulmonic area, best transmitted towards the clavicle, which frequently, in children under 4 years of age and in cases associated with pulmonary hypertension, is heard only during systole; and (6) a wide pulse pressure.

The electrocardiogram may be normal, or it may show evidence of left ventricular hypertrophy.

The roentgenographic and fluoroscopic findings are: The lungs appear congested, although usually not as much as in cases of atrial septal defect. On fluoroscopy, the branches of the secondary pulmonary arteries are seen to pulsate 2 to 3 plus. The pulmonary artery trunk is usually prominent and pulsates strongly. The left ventricle and left atrium are usually enlarged; occasionally, if the ductus is large, there may be some enlargement of the right ventricle also.

Differential diagnosis includes: 1. Venous Hum. This is usually softer and is accentuated in diastole. It may be obliterated by pressure on the jugular vein or by turning the head towards one side.

2. Aortic Stenosis and Insufficiency. The murmur is usually loudest over the aortic area and the diastolic murmur, which is usually blowing, is transmitted downwards along the left sternal border.

3. Aortic-Pulmonary Artery Septal Defect. The findings in this condition are practically the same as those in patent ductus arteriosus, and cannot be differentiated even by catheterization unless the catheter is actually passed through a ductus or through the aortic window.

4. Rupture of a Sinus of Valsalva into the Right Ventricle. Although the murmur and thrill are usually lower and there is greater enlargement of the right ventricle than in patent ductus arteriosus, the clinical differentiation usually depends on cardiac catheterization.

5. Atrial Septal Defect. This may cause confusion because it produces a systolic murmur over the pulmonic area, but is easily differentiated in that it is associated with right atrial and right ventricular enlargement, but never with hypertrophy of the left ventricle — a cardinal sign of patent ductus arteriosus.

6. Ventricular Septal Defect. When patent ductus arteriosus is manifested only by a systolic murmur, it may be difficult to differentiate it from high ventricular septal defects. Both are usually accompanied by a systolic thrill, but the murmur of patent ductus arteriosus is transmitted upwards towards the clavicle, whereas that of a ventricular septal defect is transmitted downwards along the left sternal border. The pulse pressure is usually wider in patent ductus arteriosus. The electrocardiogram and fluoroscopy in ventricular septal defect usually show enlargement of both the right and left ventricles.

Isolated Pulmonary Stenosis

The development is usually normal. There is moderate to severe dyspnea on effort, no cyanosis, and rarely, angina and syncope.

The cardiac findings are: (1) The point of maximal impulse at the third and fourth left interspaces near the sternum; (2) the apex beat palpated as a tap in the fourth or fifth left interspace at or inside the midclavicular line; (3) no systolic impulse at the pulmonic area; (4) a systolic thrill and a loud, rough systolic murmur at the second and first left interspaces near the sternum; (5) P_2 absent, or faint and pure; and 6) the blood pressure normal or low.

The electrocardiogram is characterized by pronounced right axis deviation with right ventricular hypertrophy in the unipolar chest leads. Occasionally, there may be high, pointed P waves in leads II and V_1. On fluoroscopy, the lungs are clear, especially towards the periphery. There is usually prominence of the pulmonary artery trunk which may pulsate normally, but pulsations in the branches of the secondary pulmonary arteries are always absent. There is hypertrophy of the right ventricle and, frequently, prominence of the right atrium. Occasionally, the stenosis is present at the infundibular area instead of at the valve; in such cases, the murmur may be most intense at the third left interspace, and usually no poststenotic dilatation of the pulmonary artery is seen on fluoroscopy.

Pulmonary stenosis may be associated with an atrial or a ventricular septal defect and a normal aortic root. In such cases, the findings will depend on which lesion is predominant, and cyanosis will be present if the shunt is from right to left.

Differential diagnosis includes: 1. Ventricular Septal Defect. Pulmonary stenosis, especially the infundibular type, must be differentiated from the Roger type of ventricular septal defect. In both, the murmur and thrills are most intense at the third left interspace near the sternum, and on fluoroscopy no cardiac enlargement may be detected. In the Roger type of ventricular septal defect, however, the electrocardiogram is practically normal, whereas in infundibular stenosis right axis deviation or pronounced right ventricular hypertrophy is evident.

2. Atrial Septal Defect. If the patient has been carefully examined, there should be no difficulty in differentiating pulmonary stenosis from this condition. Whereas a thrill is always present in pulmonary stenosis, it occurs only in about a third of the cases of atrial septal defect. In atrial septal defect, there is a systolic impulse at the second left interspace, which is not palpable in pulmonary stenosis. The electrocardiogram in atrial septal defect almost always shows an incomplete or complete right bundle branch block, which is rarely present in pulmonary stenosis. Fluoroscopy definitely differentiates the two conditions, for in atrial septal defect, besides the great enlargement of the right ventricle and right atrium, there is always congestion of the lung fields out to the periphery and pronounced pulsations of the branches of the secondary pulmonary arteries.

Tetralogy of Fallot

Development is usually poor. Cyanosis may not become permanent until the third or fourth month of life, although there may be paroxysmal attacks of dyspnea and cyanosis early in infancy. Clubbing and polycythemia are usually present, and there is a history of severe dyspnea on effort relieved by squatting.

The cardiac findings are: (1) The point of maximal impulse at the third and fourth left interspaces near the sternum, with a faint apex tap in the fourth or fifth left interspace inside the midclavicular line; (2) a systolic thrill along the left sternal border, present in about 60 per cent of the cases, and no systolic impulse at the second left interspace; (3) a loud, rough systolic murmur in the second and third left interspaces near the sternum; (4) P_2 usually faint or absent, occasionally accentuated, but always pure; and (5) the blood pressure normal or low. Thus the heart findings in tetralogy of Fallot are practically those of pulmonary stenosis in a cyanotic person.

The electrocardiogram shows right axis deviation and right ventricular hypertrophy in the unipolar chest leads.

Roentgenographic and fluoroscopic findings are: The lung fields are clear, especially towards the periphery, and there are no expansile pulsations of the secondary pulmonary artery branches. The over-all size of the heart is normal or small. There is a concavity of the left upper border, and the apex is usually displaced upwards. There is hypertrophy of the right ventricle and usually some prominence of the right atrium. It should be remembered that in about 25 per cent of the cases the aorta arches and descends on the right.

Differential diagnosis includes: 1. Pulmonary Stenosis with Atrial Septal Defect and Right-to-Left Shunt. In this condition, although the right ventricle and right atrium are usually larger than in tetralogy of Fallot, the differential diagnosis depends on catheterization or angiocardiography.

2. Pulmonary Stenosis with Ventricular Septal Defect and Right-to-Left Shunt. Clinical differentiation from tetralogy of Fallot is practically impossible, and the diagnosis must be made by catheterization.

3. Eisenmenger's Complex. Cyanosis usually appears late in life. On physical examination, there is a strong systolic impulse at the second left interspace and the pulmonary second sound is accentuated and closely split. On fluoroscopy, the pulmonary arteries are prominent, and there are always pronounced pulsations of the branches of the secondary pulmonary arteries.

4. Transposition of the Great Vessels. The heart is usually greatly enlarged, with involvement of both the left and right ventricles. The pulmonary second sound is usually split, indicating the existence of two valves and of adequate pulmonary circulation.

5. Tricuspid Atresia, with Pulmonary Stenosis and Normal Origin of the Great Vessels. The history is usually one of cyanosis since birth, dyspnea and squatting. In contradistinction to tetralogy of Fallot, the heart is usually enlarged and the point of maximal impulse is located at the apex, which may be displaced downwards and outwards. On fluoroscopy and roentgen examination, the lungs are clear, there are no pulsations of the branches of the pulmonary secondary arteries, and there is enlargement of the left ventricle. The electrocardiogram will clinch the diagnosis, for this is about the only cyanotic heart condition with left axis deviation and left ventricular hypertrophy.

Summary

A great number of cases of congenital heart disease amenable to surgery can be diagnosed clinically by means of a careful history and physical examination combined with electrocardiographic, roentgenologic and fluoroscopic findings. Coarctation of the aorta, aortic rings, patent ductus arteriosus, isolated pulmonary stenosis and tetralogy of Fallot are discussed from the standpoint of clinical differentiation.

4250 West Flagler Street.

1954 MEDICAL DISTRICT MEETINGS

"A" Marianna	October 11
"B" Sanford	October 13
"C" Sarasota	October 15
"D" Vero Beach	October 14

The Complex Electrocardiogram

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In cases of coronary occlusion with myocardial infarction giving a typical history and unequivocal electrocardiographic findings there is rarely any doubt as to the diagnosis of the principal underlying pathology. The presence of complicating factors of this condition must be evaluated by a complete cardiologic examination and treated as indicated.

It is, in the main, the conditions in which patients who have had one or more infarctions in the past, or a former disturbance in the conduction system, who now present themselves with symptoms suggestive of a fresh infarct that cause confusion. This confusion is, in a large measure, due to a complex electrocardiogram because of residual electrocardiographic changes from the old infarct or disturbances of the conducting mechanism. The electrocardiographic evidence of a fresh infarct may be obscured in such cases. It is my purpose here to discuss such complex electrocardiograms.

To facilitate the understanding of such tracings a brief review of the underlying factors responsible for the QRS deflections in the normal electrocardiograms, in bundle branch block and in myocardial infarction are presented.

Figure 1 shows the spread of ventricular excitation when intraventricular conduction is normal, in left bundle branch block and in right bundle branch block. It will be seen that in normal activation the right ventricular cavity potential is initially positive and then negative throughout the remainder of the period of electrical systole. This cavity potential in the right ventricle D is manifested in the electrocardiogram by a small R and deep broad S. The R is a result of the earlier activation of the septum from left to right. This is also transmitted through the resting wall of the right ventricle as seen in the complex E, close to the outside wall of the right ventricle. The deep broad S in D is due to excitation of the free wall of the left ventricle acting in a direction away from the cavity of the right ventricle plus excitation of the subendocardial wall of the right ventricle acting again away from the right ventricular cavity towards the epicardium.

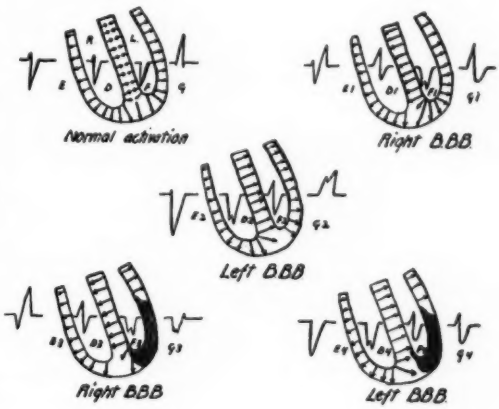

Figure 1

The complex in E shows a deep S due to preponderance of electrical forces of excitation acting away from that lead in excitation of the thicker wall of the left ventricle, overcoming the weaker electrical effect of activation of the free wall of the right ventricle acting in a direction towards that electrode. The cavity of the left ventricle is negative, F, through the entire phase of ventricular electrical systole as activation of both the interventricular septum and free wall of the left ventricle is always in a direction away from that cavity. Complex G shows a small Q representing transmission of the earliest activation of the septum from left to right. The tall R in G1 is due to activation of the free wall of the left ventricle acting in a direction toward that lead.

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Read before the Southeastern Regional Meeting of the American College of Physicians, Sea Island, Ga., Oct. 18, 1953.

In right bundle branch block it is seen that the cavity potential D1 of the right ventricle is initially more strongly positive as manifested by a taller R due to complete activation of the septum in the initial phase from left to right. The direction of the excitatory process through the entire wall of the septum is towards the right ventricular cavity. The S is due to negativity of the cavity resultant from excitatory processes now acting away from the cavity, that is, through the free walls of the right and left ventricles. The small R in E1 is due to initial early activity through the septum causing the initial positivity of the right ventricle cavity and transmitted through the free wall of the resting right ventricular muscle. The S is resultant from a transmission, also through the free wall of the resting right ventricular muscle, of the negativity of the right ventricular cavity resultant from activation now of the free wall of the left ventricle. The late R is brought about by the late activation of the free wall of the right ventricle acting in a direction towards that lead. The cavity potential of the left ventricle F1 again is negative throughout the entire electrical ventricular systole as the excitatory process is acting away from the cavity throughout the QRS phase. In G1 the R is due to preponderance of the electrical force acting in a direction towards that electrode in passage through the thicker free wall of the left ventricle than the electrical force acting away from the electrode in activation of the interventricular septum. At times a small Q may be seen because of early activation of the septum as compared to activation of the free wall of the left ventricle. The late S is due to late activation of the subendocardial surface of the wall of the right ventricle. This is the last part of the ventricular muscle to be activated and hence is unopposed. It is acting in a direction away from this electrode.

In left bundle branch block cavity potential D2 of the right ventricle is negative through electrical systole as all electrical forces in activation of both the right ventricle wall and the interventricular septum are in a direction away from the cavity. In E2 early activation of the free wall of the right ventricle is responsible for the small R. The deep broad S is transmitted now from the right ventricular cavity through the now resting free wall of the right ventricle. Now for the first time there is initial positivity of the left venticular cavity F2, due to early septal activation from right to left. This initial positivity is transmitted through the free wall of the resting left ventricle to record an R in G2. The S wave in the left ventricular cavity represents negativity due to late activation of the free wall of that chamber in a direction away from the cavity. This same activation is in a direction towards the G3 electrode and records the R1 in that lead.

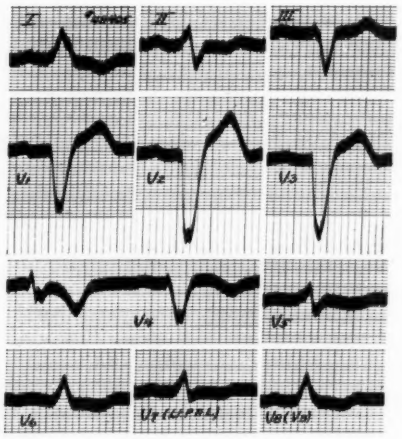

Figure 2

In the presence of an anterior infarct with right bundle branch block certain major changes are noticed. In lead E3 a Q replaces the small R as compared to lead E1. This change is due to the initial negativity of the left ventricular cavity which overcomes the earlier activation of the septum from left to right and results in the weakly positive potential as manifested by R in E1. It should be remembered that the precordial leads are not direct leads and thus record potential variations from much wider epicardial surface, in this particular instance part of the epicardial surface of the infarcted area of the left ventricle and the transmission of its initial negativity to the precordial leads. A second major change occurs in lead G3 consisting in a Q which also reflects initial negativity of the left ventricular cavity as transmitted through the underlying infarcted area.

In the presence of an anterior infarct in left bundle branch block the only change is noted in lead G4. In this lead no Q wave is seen as the infarcted area again reflects the initial cavity potential of the underlying left ventricle, which in the presence of this bundle branch block is

initially positive. It is for this reason that a diagnosis of anterior infarction in the presence of left bundle branch block cannot be determined by the precordial electrocardiogram.

An unusual tracing of anterior infarction in the presence of left bundle branch block is shown in figure 2. In lead V4 when a ventricular premature contraction occurred with a small QRS area, a sharp deep inversion of the T wave was disclosed. The electrocardiogram was taken about two months after the infarction.

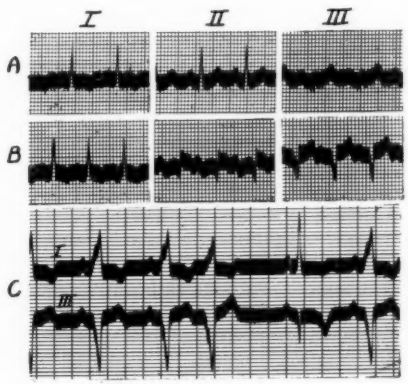

Figure 3

Figure 3 shows an example of posterior infarction obscured by a left bundle branch block except when an extrasystole occurred and was followed by a compensatory pause, whereupon the typical changes of infarction were revealed. Record A was made when the patient was complaining of anginal pain. Record B was made almost three years later and two days after symptoms of myocardial infarction. Record C shows leads I and III taken simultaneously one year later and shows the extrasystole.

In figure 4, the first tracing shows posterior infarction ten days after the attack. The precordial leads not shown here revealed only an inverted T in V6. The second tracing taken one week later shows an intraventricular block which was transient in nature and obscured the electrocardiographic evidence of the infarct. The subsequent records four years later show the block again present, and the precordial leads suggest a left bundle branch block. The findings of infarction in the standard leads are again obscured.

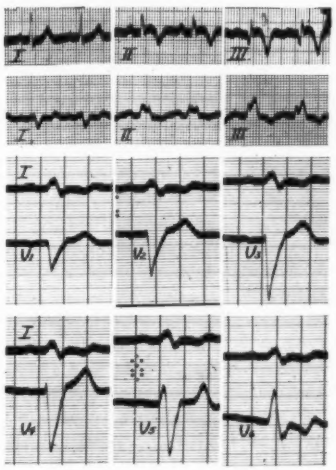

Figure 4

Anterior infarction complicated by right bundle branch block and arborization block is seen in figure 5. In this case the infarction occurred one year before the block. The Q in the precordial and standard lead I identifies the infarction. The prolonged QRS plus the late tall R's in V1, V2 and V3 identifies the right bundle branch block. The absence of the small R in V1 as normally seen in uncomplicated right bundle branch block is replaced by a Q in that lead and confirms the presence of the infarct. The late R and absence of S identify the arborization block.

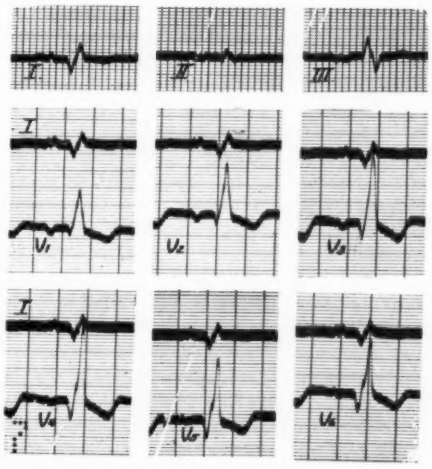

Figure 5

A most interesting tracing is seen in figure 6. Right bundle branch block is present with signs of posterior infarction in the limb leads and anteroseptal infarction in the precordial leads. The onset of the fresh anteroseptal infarction occurred 10 hours before the tracing was recorded.

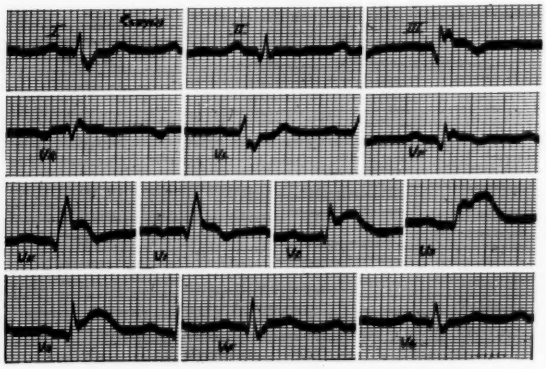

Figure 6

In figure 7 a good illustration is seen of the obscuring of the QRS of a recent posterior infarction when right bundle branch block occurred as manifested by the standard leads. A shows recent posterior infarction. B taken 11 days later shows infarction obscured by right bundle branch block. C taken 15 days later shows block no longer present and typical changes again seen.

In figure 8 in the first tracing there is evidence of posterolateral infarction. In the second tracing three days later signs of fresh infarction are present in leads II, III, Vf, V6 and V7 and right bundle branch block. In the third tracing 11 days later the more distinct QRS changes over the left precordium indicate extension of the infarcted area.

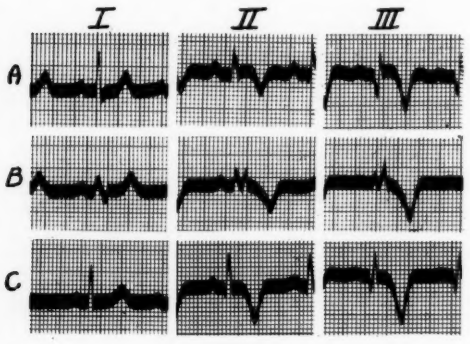

Figure 7

Summary

The complex electrocardiogram is discussed in reference to infarction in the presence of conduction defects and in reference to fresh infarctions superimposed on older infarctions. Several electrocardiographic illustrations of such conditions are presented. A review of the underlying electrophysiology responsible for such complex electrocardiograms is offered in diagram form.

The signs of anterior infarction complicated by right bundle branch block are usually absent in the standard leads and the unipolar extremity leads. The precordial leads, however, are diagnostic of the infarction. In posterior infarction in the presence of right bundle branch block diagnostic signs of the infarction are usually present in leads AVF, III and II.

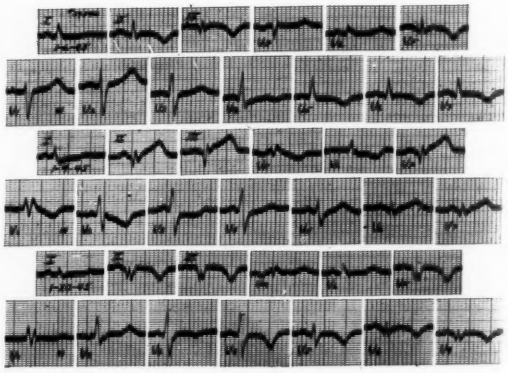

Figure 8

In the presence of left bundle branch block the electrocardiographic diagnosis of myocardial infarction can rarely be made. This difficulty is due to a failure of diagnostic changes to appear because of initial positivity of the left ventricular cavity potential which are resultant from the conduction defect.

The electrocardiographic illustrations are taken from the original collection of the late Dr. Frank N. Wilson, to whom I am indebted for permission to use them.

420 Lincoln Road.

ABSTRACTS OF MEDICAL ARTICLES

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 1018, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

The Journal of the American Medical Association is limiting its Current Medical Literature section. Thus, our main source of information on articles written by our members has been greatly curtailed.

Prolonged Drug Therapy in Peptic Ulcer. 1. An Evaluation of Banthine® as an Adjunct to Conventional Ulcer Therapy. By E. C. Texter Jr., M.D., C. W. Legerton Jr., M.D., Julian M. Ruffin, M.D., J. S. Atwater, M.D., David Cayer, M.D., F. D. Cheney, M.D., R. A. Jackson, M.D., B. G. Oren, M.D., and J. M. Rumball, M.D. South. M. J. 46:1062-1069 (Nov.) 1953.

A long range study was undertaken in an effort to answer four questions: Does the ulcer-bearing patient who is taking Banthine (methantheline bromide) daily in recommended doses fare materially better over a long period than those who are not taking the drug? Does he have fewer or less severe recurrences? Are complications less frequent? Can surgery be avoided? Banthine or atropine was administered to 292 patients in several localities: Atlanta, Ga., 71; Winston-Salem, N. C., 49; Dublin, Ga., 26; Fayetteville, N. C., 31; Miami 46; Coral Gables 9, and Durham, N. C., 60. Satisfactory data were obtained on 250 of these patients. The mean period of observation was 13 months, with a range of six to 24 months.

The questions were answered as follows: The ulcer patient fares materially better on conventional therapy supplemented by Banthine than on the same therapy with atropine. He will have significantly fewer or less severe recurrences. Complications cannot necessarily be prevented. The need for surgery cannot necessarily be avoided. It was concluded that in most patients with duodenal ulcer Banthine produces symptomatic improvement, which is inversely proportional to the clinical severity of the ulcer. The eventual course of peptic ulcer does not appear to be altered by the administration of Banthine. This drug should be used as an adjunct to conventional therapy, never as a substitute.

Management of Vesicourethral Dysfunction in Women. By Russell B. Carson, M.D. J. A. M. A. 153:1152-1155 (Nov. 28) 1953.

A review of the reasons for consultation of the last 1,000 women patients seen in private urologic practice is presented. In 52.9 per cent of these patients dysfunction of the lower part of the genitourinary tract was the primary pathologic process present. An explanation is offered for the frequent occurrences of chronic urethritis, called "sliding urethra" in this study. The management of some types of urethral and bladder dysfunction, notably urethral caruncle, cystitis, chronic cystitis, bladder neck contracture and diverticulum, is outlined. The anatomy and physiology of the vesicourethral tract are discussed with a view to clarifying the mechanism involved in the various dysfunctions.

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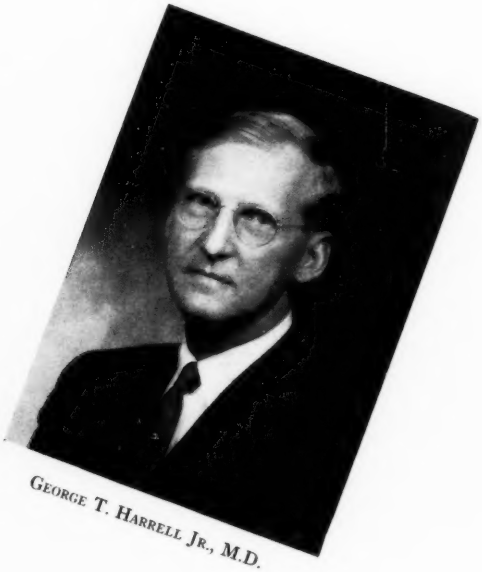

GEORGE T. HARRELL JR., M.D.

ROBERT T. SPICER, M.D.

Robert T. Spicer, M.D., Retiring Dean
University of Miami School of Medicine

Dr. Robert T. Spicer of Miami, first Dean of the University of Miami School of Medicine, was appointed to the deanship on Dec. 14, 1953. After serving with distinction in that office for nearly eight months, he resigned on Aug. 1, 1954, for health reasons, relinquishing the post to Associate Dean Marsh. Dr. Spicer reports that he has no immediate definite plans, but will continue to reside and to base his activities in Miami, where he and Mrs. Spicer have lived since June 1929.

Homer F. Marsh, Ph.D., Dean
University of Miami School of Medicine

A Hoosier by birth, Dr. Homer F. Marsh was born in Terre Haute, Ind., in 1909. He received his undergraduate degree from Indiana State Teachers College in 1930 and was awarded the degree of Master of Science in Bacteriology by Purdue University in 1932. From 1932 until 1934 he remained at Purdue, engaging in further graduate work and teaching on a part time basis. After four years spent as a diagnostic bacteriologist in a Cincinnati hospital and as a production bacteriologist with pharmaceutic firms, he resumed graduate work, and in 1941 Ohio State University granted him the degree of Doctor of Philosophy in Bacteriology. During his last year there, he held the rank of Instructor in the Department of Bacteriology.

In October 1941, Dr. Marsh joined the faculty of the University of Oklahoma School of Medicine as Assistant Professor of Bacteriology and in the next six years became Associate Professor, Professor, and finally Chairman of the Department. His research interests during this period concerned the intestinal bacteria, the mycotic diseases, and the Rh blood group antigens. In 1947, he became Associate Dean of the School of Medicine, continuing in that position until July 1952.

Dr. Marsh came to the University of Miami in August 1952 as Associate Dean of its embryonic medical school and had put together a nucleus of faculty in anatomy and biochemistry when the School of Medicine opened on Sept. 22, 1952, with its first class of 28 medical students. In December 1952 he became Acting Dean of the school and remained in that capacity until the appointment of Dr. Robert T. Spicer as Dean in December 1953, whereupon he resumed the status of Associate Dean.

On Aug. 1, 1954, Dr. Marsh was appointed Dean of the School of Medicine to succeed Dr. Spicer, whose resignation was tendered for reasons of health and became effective on that date.

George T. Harrell Jr., M.D., Dean
College of Medicine of the University of Florida

A native of the nation's Capital, Dr. George T. Harrell Jr. was born in Washington on June 16, 1908. He received the Bachelor of Arts degree in 1932 and the degree of Doctor of Medicine in 1936 from Duke University. Then he served as intern, assistant resident and resident in medicine at Duke Hospital and for two years was Instructor in Medicine at the Duke University School of Medicine. From 1941 through 1953 Dr. Harrell was associated with Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, N. C., serving successively as Assistant Professor, Associate Professor and Professor of Medicine over a period of 10 years, the last seven of which he was Director of the Department of Internal Medicine. He also served concurrently for three years during this period as Associate Professor of Preventive Medicine. The last two years there, he was Research Professor of Medicine. On Jan. 1, 1954 he became Dean and Professor of Medicine of the College of Medicine of the University of Florida.

A member of numerous medical and scientific societies, Dr. Harrell has served many of them in official capacity. In 1953 he was president of the Southern Society for Clinical Research, and since 1951 he has been chairman of the Medical Advisory Panel of the Oak Ridge Institute of Nuclear Studies. He is a member of the Commission on Chronic Illness. A contributor to many medical journals and speaker of renown, he has lectured in practically every Southern state and in all sections of the country, having delivered such important national lectures as the Kellogg Lecture of 1953 and the Alpha Omega Alpha Lecture at Harvard.

Dean Harrell's research interests are in infectious diseases, in which he has made notable contributions through the study of alteration of fluid balance during infection by radioisotopic technics; antibiotic therapy with penicillin, streptomycin and Aureomycin; and the application of radioisotope technics to the study of physiologic changes in myxedema and other metabolic problems. He has held a number of important research grants, and he received the First Scientific Award at the 1953 meeting of the Southern Medical Association for his research work on the cellular changes of sodium and potassium in man. On invitation, he has presented the results of his research at the universities of Oxford, Padua, Naples, Liége, Leiden, Brussels, and London and also has addressed the International Physiologic Congress at Oxford and at Montreal.

Program for the University of Miami School of Medicine

In its two years of operation, the University of Miami School of Medicine has expanded its first year class to 65 students. Its full time faculty has increased to 28 members, and about 50 members of the Dade County Medical Association are members of the faculty on a voluntary basis. Foundations are being poured now for a new Outpatient Clinic Building on the grounds of the Jackson Memorial Hospital to provide adequate clinic teaching facilities for the school. Architects are drawing plans for a new Medical Sciences Building, also to be located at the Jackson Memorial Hospital, to replace the present temporary quarters of the basic science departments. Within two years, the entire medical school will be located at the Jackson Memorial Hospital, which will provide adequate clinical teaching material.

The clinical departments of instruction will be organized around a small nucleus of full time men with the practicing physicians of Dade County constituting the majority of the faculty in these areas.

It is the basic attitude of the administration of the medical school that the school has but one fundamental reason for being, namely, to train young men and women to take their places in the practice of general medicine. No attempt will be made in the undergraduate curriculum to stress the special areas of medicine although the students will be given sufficient basic training in those areas to permit them to continue with graduate work as desired. Ancillary activities will of course be developed as soon as possible.

It is a basic premise of the administration of the medical school that such an institution has two fundamental obligations to the people of Florida. It is an obligation to train the best possible physicians to give care to the citizens of Florida, and it is an obligation to encourage, in all possible manner, an adequate distribution of the school's graduates throughout the state. Development of a sound curriculum will accomplish the former need, and development of programs showing the advantages of locating in the smaller communities of the state will accomplish the latter.

Homer F. Marsh, Dean

Program for the College of Medicine of the University of Florida

Construction of the College of Medicine is under way at the University of Florida. The design of the physical plant and curriculum is based on an extensive study, supported by the Commonwealth Fund, of the needs of the state and the type of medical school which should be established.

The primary task of the College of Medicine is education. Medical students will be trained through a broad University-wide program of teaching, research and care of patients to apply scientific tools and methods to the practice of the art of medicine. The curriculum will emphasize all phases of health so that the future family physician will learn to work with members of other professions as a team. Many unusual features in the building emphasize that in medicine the student has embarked on a never ending process of self education. The intellectual tools and technics of study used throughout his professional life are introduced in the freshman year through an individual study cubicle.

Medical care is best given by the family physician in the local community, where the effect of illness in one member of the family on all of the others in the home environment is seen. Physicians throughout the state will serve as preceptors for senior students assigned to them to emphasize the practical application of theoretic training in the highly personal, confidential relationship between a doctor and his patient.

All members of the Florida Medical Association are cordially invited to visit the campus at Gainesville and discuss the plans for the College of Medicine. A room is being built for the use of any physician in the state who wishes to study or attend teaching exercises. A unique ambulant patient facility is planned as part of the teaching hospital — the second unit of the Health Center. Patients will be referred by their physicians. The Health Center has been planned to serve the entire State of Florida as an extension of the strong right arm of the doctor at home and to be a facility of which the profession can be justly proud.

George T. Harrell, Dean

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Making Doctors

> To study the phenomena of disease
> without books is to sail an
> uncharted sea, while to study
> books without patients is
> never to go to sea at all.
> Osler: Books and Men

In order to appreciate the pattern of training of a medical student, one must peer into the past and review the obligation owed today to traditions developed through centuries of man's struggle with disease. Obviously, this training deals first with the patient himself, as an individual, and second with the treatment of his disease, whatever it may be. The first of these objectives, the confidential relationship of an individual doctor with an individual patient, was clearly enunciated by Hippocrates two thousand years ago and has withstood the test of time, determining the pattern of medical ethics from that early day to the present.

The second objective, the training of the student in the treatment of disease, naturally has altered across the years with the changing concepts of disease and disease processes. Down through the centuries medicine, referred to only as the Art by Hippocrates and his successors up to modern times, has turned for help to magic, to astrology, to alchemy, to religion, and most recently to science. Today, these changes in alliance of medicine to contemporary philosophy are also manifest in the definite and not inconsiderable effect of the present social and economic change upon the teachers and the teaching of medicine.

What are the aims of medical education at the present time, and in what way are they being achieved? So great has been the impact of science upon medicine as to eclipse the art in recent decades. In the words of Sir Auckland Geddes, "So many come to the sick room thinking of themselves as men of science fighting disease and not as healers with a little knowledge helping nature to get a sick man well." Today the immediate trend is toward an appropriate synthesis of healer and scientist, and the highest type of medical training is accomplished through a threefold program of teaching, research and care of patients whereby the student learns to apply scientific tools and methods to the practice of the art of medicine. The many facets of the subject of medical education at the present time are aptly set forth in the address of Dr. Wilburt C. Davison, Dean of Duke University School of Medi-

cine, presented at the Eightieth Annual Meeting of the Florida Medical Association last April, which is published in this issue of The Journal.

Inherent in the practice of medicine as a profession are a desire and a responsibility to serve the people. In their statements appearing in the editorial section of this number of The Journal, Dean Marsh of the University of Miami School of Medicine and Dean Harrell of the College of Medicine of the University of Florida both emphasize that the purpose of Florida's two medical schools is to train doctors to serve adequately the needs of this state with its rapidly growing population. The keynote of these two major ventures is service for all sections of the state.

The present philosophy of medical education not only stresses service adequate to meet the needs of the people, but it also wisely does not overlook — in fact, it emphasizes — the broad concept of general education of the professional person. For that reason, Florida is fortunate to have each of its new medical schools an integral part of a university program, where the contributions of different phases of education can best be recognized and utilized. Education in the light of the total personality of its medical students will receive due attention in this state. Dr. Russell S. Poor recently expressed this aspect of professional training in these words: "If the possible contributions of general education to the acquisition of the tools of learning are overlooked, if the possible contributions of the humanities to aesthetic and cultural values are ignored, if the possible contributions of the social sciences to an understanding of community problems are not valued highly — if these and other possible contributions of different disciplines are not considered as vital and related elements in the education of a physician, the educational process is not complete. Moreover, the physician is neither so good a practitioner of medicine nor so effective a citizen as he could have been."[1]

Now that Florida is undertaking for the first time the training of her future physicians, the two medical schools are being developed at a propitious time to meet her growing needs. The magnitude of the task precludes faint heart and bespeaks warm support for the universities and the able educators who with enthusiasm and zeal are valiantly undertaking this vitally important mission.

1. Poor, R. S.: Planning Florida's Health Leadership: A Summary, Gainesville, University of Florida Press, 1954, p. 1.

Florida Benefits Under Hill-Burton Act

Senator Lister Hill, co-author of the Hill-Burton Act, which provides federal funds for the erection of hospitals on the basis of community need, reminded Floridians recently of the benefits already accruing to them from this source. The veteran Alabama solon, son of a rural surgeon, was the guest speaker at the tenth annual dinner commemorating the founding of the Florida Blue Cross, held in Jacksonville early in July.

Named for Lord Lister, the father of modern antiseptic surgery, this distinguished legislator pointed out that participation by the federal government in the building of state and municipal hospitals and other health facilities, coupled with the simultaneous extension of voluntary health insurance, has given pressure groups advocating socialized medicine a real setback. He was, however, quick to warn the 350 physicians and hospital officials in attendance that these proponents of compulsory federal health insurance, while temporarily checked, are by no means defeated. They will not be defeated, he said, until two problems, the availability of hospital facilities in areas in need of such facilities and the higher cost of medical care, have been solved.

"Within our day and almost within our generation, the hospital has evolved from a refuge for the dying to a necessity for the living," the Senator stated. "The revolution in medical practice and the evolution of the hospital from a refuge for the few to an institution recognized as essential to the lives and health of all of us have produced in the minds of the American people a new concept of medical care. We have lifted our sights both as to the quality of the medical care we expect and as to its availability."

He found in Florida an excellent example of how the philosophy of the Hill-Burton Act has worked. In this state, as in the nation as a whole, there were available at the beginning of the program only about one half the general hospital beds needed, and there was even greater lack of facilities for the care of mental patients and those with tuberculosis and chronic disease. With the financial aid and incentive from the act, Floridians promptly achieved an outstanding record in the building of hospitals and health facilities. "Beautiful new hospitals — modern in every detail — began to open their doors in community after community which had no hospital of any

kind before, providing the finest workshops for your doctors and making it possible for them to bring you the best in medical care," he declared. "The building of hospitals and health facilities in Florida under the program has been limited only by the amount of funds appropriated pursuant to the act. The new urge to build hospitals refused to recognize these limitations and you have gone beyond the program and built hospitals outside the program."

The responsibility for administering the Hill-Burton program in Florida is vested in the hospital division of the State Improvement Commission, established in August 1946, the same month that the Congress approved the Federal Hospital Survey and Construction Act. On May 8, 1948, nearly two years later, Florida had the distinction of dedicating the first Hill-Burton hospital in the United States, the Suwannee County Hospital in Live Oak, which was opened on Aug. 12, 1948.

During the last six years, 65 per cent of the 2,827 general hospital beds for acutely ill patients which have been constructed received assistance through the Hill-Burton program. In the same period, 6,856 beds of all categories were constructed, with 37 per cent receiving grant-in-aid funds. Ten of these beautiful new plants were pictured recently in the Journal of the American Medical Association.[1] Of 55 projects receiving Hill-Burton grants, 30 have been completed at a total cost of $29,581,362, including a federal contribution of $10,229,753, and have supplied 2,542 additional beds. At the present time 12 projects are under construction, and 13 others have been approved for participation in the program, but are not yet under construction.

As of May 1, 1954, the cost of Hill-Burton hospital and health center construction, completed or approved for participation, was $44,044,703, and of this amount 31 per cent was federal grant-in-aid funds. The state agency now has before it inquiries for further construction of projects estimated to cost $62,871,701, for which grant-in-aid funds amounting to about $24,091,022 are needed. The average cost per bed of construction in Florida, approximately $13,000, is slightly less than the average for the southeastern area of the United States. There has been the same percentage of construction of hospitals in the range of 25 to 49 beds as in the range of 100 to 199 beds.[1]

Hill-Burton aid has brought hospitals to Florida areas previously without facilities to render medical care, thereby drawing new doctors to these areas. The greatest relative financial assistance has gone to hospital areas of relatively poor economic status. The rapid growth in population poses a problem for Florida, shared only by two other states, for this growth is not fully reflected in the federal population figures required for computing bed need as well as the state's share of grant funds. Because of the continued urgent need for construction funds in the rural areas, Hill-Burton funds will not be used for Florida's rehabilitation hospital for alcoholics now being developed, nor for the proposed hospital to be operated in conjunction with the new medical school being established at the University of Florida in Gainesville. The facilities of the Jackson Memorial Hospital in Miami will be used for teaching purposes by the new University of Miami School of Medicine, now in its second year of operation.

Florida's rapid progress in providing hospital facilities where most needed should be highly gratifying to every citizen of the state. Senator Hill offered a timely reminder in the concluding words of his address: "As we bring the benefits of hospital and medical care to our people, we are building the health and strength of our people. We are building the strength of America. We are making America strong that we may keep America free."

1. Hospitals Built with Hill-Burton Aid, J. A. M. A. 155: 582-583 (June 5) 1954.

A Concrete Constructive Program of Public Relations

Emphasizing the positive, in medicine as elsewhere, gives the spirit a lift that is both constructive and exhilarating. The positive note in Florida medicine is well exemplified in the public relations program of the Florida Medical Association.

Not long ago every member of the Association received an attractive brochure containing an outline of the Association's Public Relations Program which was approved by the House of Delegates. On the inside of the front cover a message from Dr. Edward Jelks, Public Relations Liaison Member of the Board of Governors, emphasized the positive nature of this program, which rests primarily upon service to the public and has been developed through broadening the scope of many past activities and adding new projects based upon sound and proved public relations principles.

Dr. Jelks praised the county medical societies throughout the state for the outstanding progress they have made in the many phases of the public relations program through numerous activities of service to the public. He also urged each member to study the outline in the brochure with a view to taking inventory of local activites and further developing an active well rounded program for his county society.

In attractive form under five headings the brochure presents the salient features of the program. Careful perusal of this outline enables each member to familiarize himself with the many phases of this vitally important aspect of medicine today at the county society level.

The brochure also reminds the members that the Board of Governors, through its Public Relations Liaison Member, and the Association's Bureau of Public Relations with its staff and facilities are available to the component county societies in initiating and implementing local programs. Also, on the state level there is a Public Relations Advisory Committee composed of the Public Relations Committee chairmen of five component county societies. The advice and work of this Committee are of great value in formulating and implementing programs that will best meet the various public relations needs of component county societies and the Association's over-all program. General information and specific data pertaining to the individual phases of the program are always available from the Bureau of Public Relations at Association headquarters.

To enable each member to visualize and evaluate the activites of his county medical society the brochure has a convenient form on the inside of the back cover. Did you check it on your brochure, as requested? If not, check the reproduction presented here as a guide to progress in your county society's public relations program and then act upon the information gained to broaden the scope of the program.

DOES YOUR COUNTY MEDICAL SOCIETY'S PUBLIC RELATIONS PROGRAM INCLUDE . . .

Medical Care For All By	**Yes**	**No**
The guarantee of a physician's services to every citizen	[ ]	[ ]
An efficient emergency call service which has been publicized	[ ]	[ ]
Promoting the personal physician concept	[ ]	[ ]
An adequate indigent medical care program	[ ]	[ ]
Hospital facility expansion if needed	[ ]	[ ]
Physician placement in areas where needed	[ ]	[ ]
A program of rural health	[ ]	[ ]
An active grievance committee which has been publicized	[ ]	[ ]
Paying For Medical Care Through		
Promoting the discussion of fees between physician and patient	[ ]	[ ]
Promoting voluntary health insurance	[ ]	[ ]
Sponsoring a Budget for Health plan	[ ]	[ ]
Information and Education Through		
Medical Forums	[ ]	[ ]
Feature newspaper articles	[ ]	[ ]
Radio-TV programs, live or transcribed	[ ]	[ ]
An active speakers' bureau	[ ]	[ ]
Sponsoring of fair exhibits and displays	[ ]	[ ]
A Press-Radio-TV Code of Cooperation	[ ]	[ ]
Press-Radio-TV Conferences	[ ]	[ ]
Working With Others By		
Participation of the Woman's Auxiliary	[ ]	[ ]
Cooperation with allied groups	[ ]	[ ]
Cooperation with other professional groups	[ ]	[ ]
Physicians' participation in civic organizations	[ ]	[ ]
Physicians' participation in community projects	[ ]	[ ]
Liaison with organized labor	[ ]	[ ]
Coordination and planning with governmental and independent agencies	[ ]	[ ]
Medical Society's Unity Through		
Promoting active participation by all medical society members	[ ]	[ ]
Indoctrination of Members, Internes, Residents, Medical Students	[ ]	[ ]

Reinsurance Plan Shelved

On July 13, 1954, the House of Representatives by a vote of 238 to 134 recommitted to the Committee on Interstate and Foreign Commerce President Eisenhower's proposed bill for reinsurance of prepaid health plans. House Leader Halleck (Ind.) was quoted by the press as saying recommital would kill the measure. The President, however, in a press conference referred to the House rejection of the measure as merely a temporary setback and declared his intention to keep fighting for the program.

In the resulting political controversy the American Medical Association has been blamed by some newspapers for "defeat" of the bill. It did oppose the measure, but was by no means alone in its opposition. Most of the nation's insurance experts also opposed it. The one salient conclusion of the opposing group was that the bill, as considered by the Congress, would add nothing to the present rapidly expanding and successful health insurance field.

Shortly before the Congress took its action, the Board of Trustees of the American Medical Association reiterated its opposition to the bill. Said Dr. Walter B. Martin of Norfolk, Va., presi-

dent of the A. M. A.: "While the administration has repeatedly stated that the bill does not involve federal subsidies, it is our opinion that federal subsidization of the private insurance industry is an inevitable result."

The six principal reasons for A. M. A. opposition to the bill are:

1. The mechanism suggested will not accomplish the stated purposes of the bill: to promote the best possible medical care on reasonable terms.

2. The phenomenal progress of the health insurance industry makes federal intervention not only unnecessary but a dangerous intrusion into a successful area of private enterprise. Such intervention would not help and could hinder continued expansion of health insurance coverage.

3. 'Reinsurance' would not make health insurance more attractive to persons who can afford to pay premiums and have not done so. It would not make health insurance available to the indigent unless the government provides a subsidy for the purpose of selling insurance for less than the cost of servicing the contract.

4. The program, without subsidy, would not reduce the cost of insurance, nor would it make health insurance available to any additional groups or geographic area that voluntary insurers cannot reach.

5. Most insurance authorities agree that the extent of health insurance liability is such that a federal reinsurance program is absolutely unnecessary.

6. The measure would place extensive regulatory power in the Secretary of Health, Education and Welfare. The concentration and delegation of such authority and control over a vital branch of American industry in an Executive Department of the government without clear and convincing evidence of need cannot be justified.

Congressman Williams of Mississippi, in describing on the House floor what the reinsurance bill means, said: "I took my youngster out to the park about two months ago, and she saw them selling cotton candy, all pink and pretty and inviting. Naturally, she had to have some. That cotton candy was pretty. It tasted sweet and smelled sweet, but when she tried to bite into it she found nothing there. This bill is like that cotton candy, all air and no substance, but cost-[illegible]."

San Francisco A.M.A. Meeting

Since 1871 the American Medical Association has been meeting periodically in annual session in San Francisco. For the eighth time in 83 years its members gathered there the week of June 21-25, 1954, this time for the 103rd Annual Meeting, and some 100 Florida physicians returned from California's great metropolis with delightful recollections of a profitable and enjoyable occasion. The proceedings of the 1871 and 1894 meetings contain no record of attendance, but 2,307 physicians attended the third San Francisco meeting in 1915; 3,726 the fourth, in 1923; 6,034 the fifth, in 1938; 7,746 the sixth, in 1946; and 10,119 the seventh, in 1950. This yardstick of growth lends interest to the all time high record at the recent meeting when 12,063 physicians and 30,906 guests brought the official total to 42,969, exceeding by several hundred the total for the 1953 New York meeting.

In their excellent report appearing in this issue of The Journal, the able representatives of the Florida Medical Association, Dr. Louis M. Orr and Dr. Reuben B. Chrisman Jr., and Dr. Thomas H. Bates, alternate for Dr. Herbert L. Bryans, present the highlights of the organizational side of the activities of the San Francisco meeting. Almost 90 resolutions were placed before the House of Delegates for consideration, and this review of the action taken on important matters will be of particular interest to all Association members.

In contrast to the 21 sections in the Scientific Assembly today, back in 1871 the American Medical Association boasted four sections, namely, Practice of Medicine and Obstetrics, Materia Medica and Chemistry, Surgery and Anatomy, and Meteorology and Epidemics. At that time its library, housed in the Smithsonian Institution in Washington, D. C., consisted of 339 volumes, reprints, periodicals and monographs. The report of the treasurer at that first San Francisco meeting showed a cash balance on hand of $704.32.

The tremendous expansion and growth of this organization, however, have not changed the purpose for which it was founded more than a century ago. Across the years the central theme of the annual meetings has been to promote the science and the art of medicine and the betterment of the public health. Annually, this purpose is emphasized through scientific exhibits, of which there were 220 this year. Exhibits on cardiovascular surgery received particular acclaim, and

a new feature was the question and answer conference on cardiovascular diseases presented in cooperation with the American Heart Association. The exhibits on fractures and on fresh pathology were especially popular, as in former years.

A quiz corner sponsored by the editorial boards of the special journals published by the American Medical Association was another new feature which was timely and evoked interest. It served as a consultation center where members of these editorial boards representing various specialties answered questions from physicians and advised them with regard to the publication of material that they might have available. Also, medical writing by the general practitioner was the subject of one exhibit. Here it was pointed out that the general practitioner sees 85 per cent of sick persons, but nongeneral practitioners do 95 per cent of medical writing. A collection of reprints of articles published by general practitioners in various journals was presented.

Likewise of vital importance in emphasizing the association's purpose are the individual meetings of the 21 scientific sections, and at this meeting about 300 papers were presented on all aspects of medical practice. Legal medicine was one of the newer additions to the program which attracted excellent attendance.

Interest now turns to the forthcoming Clinical Meeting to be held in Miami, November 29 through December 2. Florida now has an opportunity to extend its hospitality to the medical profession of the nation as graciously as did California earlier in the year. The Association rests assured that under the leadership of Dr. Homer L. Pearson Jr., general chairman, Miami with unique distinction will extend as hearty a welcome and offer as rewarding an experience as did San Francisco.

Registration

Total registration of Association members at the 1954 A.M.A. annual meeting in San Francsico was 89. Members in attendance were:

ARCADIA: Charles H. Kirkpatrick. BOCA RATON: William G. O'Donnell. BRADENTON: Willett E. Wentzel. CANTONMENT: Stanley G. Childers. CLEARWATER: Harvey J. Howard. CORAL GABLES: Jack Q. Cleveland, F. E. Kitchens, Joseph R. Morrow, Frederick P. Poppe, Louis C. Skinner Jr. DANIA: Fred E. Brammer. FORT LAUDERDALE: Burns A. Dobbins Jr., Garland M. Johnson, Richard A. Mills, Francis D. Pierce, George T. F. Rahilly. GREEN COVE SPRINGS: Edwin H. Brown. HOLLYWOOD: Louis J. Novak, Randall W. Snow. JACKSONVILLE: Sullivan G. Bedell, Lee E. Bransford Jr., Silas M. Copeland, Wm. S. Manning, John H. Mitchell.

LAKE CITY: Thomas H. Bates. LAKELAND: S. Allen Clark, Louis J. Polskin. MIAMI: Reuben B. Chrisman Jr., Milton M. Coplan, Carl H. Davis, Edward F. Fox, R. Spencer Howell, Paul S. Jarrett, George D. Lilly, James K. McShane Jr., Donald F. Marion, Benjamin G. Oren, Homer L. Pearson Jr., Max Pepper, William C. Phillips, Gerard Raap, John R. Ramey, Donald G. Stannus, Richard F. Stover, Herbert W. Virgin Jr. MIAMI BEACH: Bernhard Baer, Theodore M. Berman, Irvin M. Greene, Walter T. Hotchkiss, Maurice Kovnat, Alexander Libow, Cayetano Panettiere, Randolph Shevach, Nicholas A. Tierney.

MIAMI SPRINGS: Estella G. Norman. OCALA: Hugh H. Barfield. ORLANDO: Clarence Bernstein, L. Paul Foster, Lewis L. Kline, Morris H. R. Lukens, Pleasant L. Moon, Louis M. Orr, Robert W. Young. PALM BEACH: Burton F. Barney. PATRICK A. F. B.: James T. Hardy. PENSACOLA: Wilton E. Tugwell. ST. AUGUSTINE: Vernon L. Lockwood. ST. PETERSBURG: Dean W. Hart, Peter B. Kersker, James K. McCorkle, Robert J. Needles, Benjamin H. Sullivan. SARASOTA: John M. Butcher, Joseph Halton, Andrew J. Jesacher. SOUTH MIAMI: Franklyn E. Verdon. TALLAHASSEE: Benjamin A. Wilkinson. TAMPA: Frank S. Adamo, James N. Patterson, Richard C. Rodgers, Burdette Smith, Alvard L. Stone. VERO BEACH: Vernon L. Fromang. WEST PALM BEACH: V. Marklin Johnson, Theodore Norley, S. Richard Ombres, Cecil M. Peek.

CHAMBLEE, GA.: Edward E. Cava. ALEXANDRIA, LA.: Thomas C. Black.

1954 MEDICAL DISTRICT MEETINGS

"A" Marianna	October 11
"B" Sanford	October 13
"C" Sarasota	October 15
"D" Vero Beach	October 14

Report of Delegates to the American Medical Association 103rd Annual Meeting, June 21-25, 1954, San Francisco

The Florida Medical Association was represented at the 103rd Annual Meeting of the American Medical Association by its delegates, Dr. Louis M. Orr and Dr. Reuben B. Chrisman Jr., and Dr. Thomas H. Bates, alternate for Dr. Herbert L. Bryans. In addition, Mr. Ernest R. Gibson, Managing Director, and Mr. W. Harold Parham, Supervisor of the Bureau of Public Relations, were in attendance, as was Mr. John C. Lee, Executive Secretary of the Dade County Medical Association.

The final registration total for the San Francisco meeting was 42,969, made up of 12,063 physicians and 30,906 guests including nurses, medical students, exhibitors and wives and families of physicians. This exceeded the record-smashing attendance at the New York meeting of 1953 where the total registration reached an all time high of 42,144. There were 101 Florida physicians registered, many of whom were accompanied by members of their families.

Florida's representatives received considerable notice and achieved an excellent record for their activities. Dr. Orr's report for the Council on Medical Service received high praise. It was unanimously approved, as was his special resolution condemning the present practice of establishing service connection for veterans' disabilities by legislative fiat. Dr. Chrisman headed the Reference Committee dealing with all resolutions or proposed amendments to the Constitution and By-Laws. A number of changes were proposed and, because of the efficient manner in which he handled the Committee, he received considerable praise. Dr. Homer L. Pearson Jr., a member of the Judicial Council, was elected the new Chairman of that body, succeeding Dr. Edward F. Cunniffe of New York who served as Council Chairman for many years.

Fee splitting, osteopathy, closed panel medical care plans, veterans' medical care and the training of foreign medical school graduates were among the major subjects of discussion and action during the sessions of the House of Delegates.

Named as president-elect for the coming year was Dr. Elmer Hess of Erie, Pa., who, until his election, was serving as a member of the House of Delegates and as Chairman of the Council on Medical Service. Dr. Hess will become president of the American Medical Association at the June 1955 meeting in Atlantic City, succeeding Dr. Walter B. Martin, of Norfolk, Va. Dr. Martin took office at the Tuesday evening inaugural session in San Francisco's Palace Hotel.

The House of Delegates voted the 1954 Distinguished Service Award of the American Medical Association to Dr. William Wayne Babcock of Philadelphia for his outstanding contributions to medicine and humanity. Dr. Babcock, who was professor of surgery and clinical surgery at Temple University School of Medicine from 1903 to 1944, received the award from Dr. Martin at the Tuesday evening inaugural ceremony.

Fee Splitting

The House adopted a supplementary report of the Reference Committee on Miscellaneous Business which recommended acceptance of a Judicial Council report on the subject of billing and made the additional recommendation "that the House of Delegates resolve that it firmly opposes fee splitting, rebating or payment of commissions in any guise whatsoever and that it further opposes any mechanism that encourages this practice."

Osteopathy and Medicine

Four resolutions dealing with the osteopathic problem were considered. The House accepted a recommendation by the Reference Committee on Medical Education and Hospitals and adopted a Supplementary Report of the Board of Trustees on a Report of the Committee for the study of Relations Between Osteopathy and Medicine, which recommended (1) that direct on-campus observation and study of osteopathic schools be made and (2) that no action be taken on the report at this time and that final action be deferred until December 1954. It further recommended that the Committee be continued until December 1954, in order to be available to evaluate education in schools of osteopathy should the house of delegates of the American Osteopathic Association act favorably upon the recommendation of its Conference Committee.

Closed Panel Plans

The much publicized New York resolution, calling for several changes in the Principles of Medical Ethics relative to participation in closed panel medical care plans, was considered by the Reference Committee on Miscellaneous Business. That Committee made the following recommen-

dations, "since this will require clarification and interpretation of the Principles of Medical Ethics in relation to prepaid medical care plans and as set forth in the bylaws, the Judicial Council has jurisdiction on all questions of medical ethics.

"Therefore, your reference committee recommends that the House of Delegates request the Judicial Council to . . . investigate the relations of physicians to prepaid medical care plans and render such interpretations of the Principles of Medical Ethics as the Council deems necessary, and report to the House of Delegates not later than the next annual meeting of the Association."

Foreign Medical Graduates

Three resolutions and a Board of Trustees supplementary report were submitted to the House regarding the evaluation of foreign medical school graduates, a subject which attracted major interest earlier this year at the annual Congress on Medical Education and Licensure in Chicago.

The Reference Committee on Medical Education and Hospitals spent much of its time listening to the ideas and proposals of various state medical societies, state licensing boards, members of the Council on Medical Education and Hospitals and others. The reference committee recommended that "the intent and aims of this Supplementary Report and the three resolutions can best be met by referring the entire problem to the Council on Medical Education and Hospitals for further study. It is recommended that the Council report at the Interim Session in 1954 regarding the progress relative to this study."

Seal of Acceptance

The Council on Medical Service presented a supplementary report outlining the difficulties encountered in conducting the Seal of Acceptance program, and recommending discontinuance of the Seal of Acceptance for voluntary health insurance plans. The House adopted the Council report, thus terminating the Seal of Acceptance program for voluntary health insurance plans.

Registration of Hospitals

The House also approved a Board of Trustees report calling for discontinuation of the registration of hospitals by the Council on Medical Education and Hospitals and suggesting that the Joint Commission on the Accreditation of Hospitals be requested to undertake the registration of hospitals in addition to its present accreditation activities.

Miscellaneous

Among a wide variety of other actions the House also:

Voted to continue the holding of the annual Clinical Meetings;

Approved the establishment of a program of Medical Military Scholarships with appropriate safeguards limiting the number of students involved;

Approved the extension, on a voluntary basis, of the Medical Education for National Defense program which currently is in operation in five medical schools as a pilot study, and

Authorized the Council on Scientific Assembly to conduct a thorough study of the use of tape recordings of the material presented at meetings of the Council, and asked for a report at the December meeting.

The Reference Committee on Medical Education and Hospitals did not approve the resolution from Florida (Pinellas County), which sought to limit the activities of the Board for accrediting hospitals.

Opening Session

Highlights of the opening House session on Monday were selection of Dr. Babcock as recipient of the Distinguished Service Award and the addresses by Dr. Edward J. McCormick of Toledo, then president of the Association, and Dr. Martin, then president-elect.

Dr. McCormick called upon the medical profession to take the guesswork out of medical costs by adopting average fee schedules on an area or regional basis. The Reference Committee on Reports of Officers later suggested that the Board of Trustees make a study of such programs where they already are in operation, and the House approved.

Dr. Martin, in his opening session address, declared that the most urgent problem before the medical profession is that of financing hospital services to make them more generally accessible. In his presidential inaugural address, Dr. Martin said that physicians are duty-bound to keep themselves informed on public matters affecting the medical welfare of the people, and he also urged doctors to "reach back farther than the disease" in treating their patients.

Special Citations

Two special citations were presented by the Association during the San Francisco meeting.

During the presidential inauguration ceremony Dr. McCormick presented an award to a fellow Toledoan, Dr. Nicholas P. Dallis, for his outstanding health educational service as the writing member of the team that produces the illustrated feature, "Rex Morgan, M.D." At the closing House session on Thursday, Dr. Martin presented a special citation to Smith, Kline and French Laboratories of Philadelphia for "pioneering use of television in bettering the health of the nation." The plaque was accepted for the Company by Mr. Francis Boyer, President.

The closing session also brought the announcement that the California Medical Association had presented a check for $100,000 to the American Medical Education Foundation.

Election of Officers

The election at the closing session brought the following results, in addition to the selection of Dr. Hess as president-elect, whose nomination was seconded by Dr. Orr:

Dr. Clark Bailey of Harlan, Ky., was named vice president.

Dr. David B. Allman of Atlantic City and Dr. F. J. L. Blasingame of Wharton, Tex., were re-elected to their positions on the Board of Trustees.

Also re-elected were Dr. George F. Lull of Chicago, Secretary, whose nomination was seconded by Dr. Bates; Dr. J. J. Moore of Chicago, Treasurer; Dr. James R. Reuling of Bayside, N. Y., Speaker of the House of Delegates, and Dr. Vincent Askey of Los Angeles, Vice Speaker.

The House of Delegates also chose New York City as the place for the 1957 annual meeting, San Francisco for 1958 and Atlantic City for 1959. Previously selected were Atlantic City for 1955 and Chicago for 1956. The dates of next year's meeting in Atlantic City are June 6-10.

The Clinical Session for 1954 will be in Miami, November 29-30, December 1-2.

The 1955 Clinical Session will be in Seattle, while that of 1956 goes to Boston.

No report of Florida's participation in the activities in the 103rd Annual Meeting of the American Medical Association would be complete without giving due praise and credit to the activities of Mr. Gibson, Mr. Parham and Mr. Lee, all of whom were most helpful to your delegates. It was noticed that the lay representatives of other state medical associations were frequently seen seeking out these gentlemen in an effort to learn more about the Florida Medical Association and the work of the Dade County Medical Association in preparation for the 1954 Clinical Session of the American Medical Association, which will be held in Miami November 29-30, December 1-2. We can well be proud of these fine gentlemen.

Respectfully submitted,

Louis M. Orr
Reuben B. Chrisman Jr.
Thomas H. Bates

Southeastern States Cancer Seminar Miami, Dec. 2-4, 1954

The Southeastern States Cancer Seminar will be held this year at the McAllister Hotel in Miami immediately following the Clinical Session of the American Medical Association. The dates for this seventh annual meeting are December 2, 3 and 4. There should be a record attendance since many physicians attending the Clinical Session will undoubtedly wish to remain over for the Cancer Seminar. The Seminar is sponsored by the American Cancer Society, Florida Division, the Florida State Board of Health and the Dade County Medical Association.

The speakers and the subjects they will discuss are: Dr. William H. Baker, Boston, "The Role of Hormones in Breast Cancer;" Dr. J. A. del Regato, Colorado Springs, Colo., "The Role of Radiotherapy in the Treatment of Cancer of the Larynx" and "The Treatment of Cancer of the Lower Lip;" Dr. Charles L. Martin, Dallas, Texas, "The Treatment of Cancer of the Fundus of the Uterus;" Dr. Joe Meigs, Boston, "The Surgical Treatment of Cancer of the Cervix;" Dr. J. Elliot Scarborough, Emory, Ga., probably discussing cancer of the larynx; Dr. Danley P. Slaughter, Chicago, "The Surgical Treatment of Cancer of the Oral Cavity;" Dr. J. Urban, New York City, "Diagnosis and Surgical Management of Breast Cancer;" Dr. Owen H. Wangensteen, Minneapolis, "Cancer of the Stomach;" Dr. Willet Whitmore, New York City, "Diagnosis and Treatment of Testicular Neoplasms;" Dr. Alton Ochsner, New Orleans, probably discussing cancer of the lung; Dr. Richard Cattell, Boston, "Malignancy of the Colon and Rectum;" and Dr. Elson B. Helwig, Washington, D. C., "The Pathology of Carcinoma of the Cervix."

Florida Academy of General Practice Scientific Assembly October 17-18

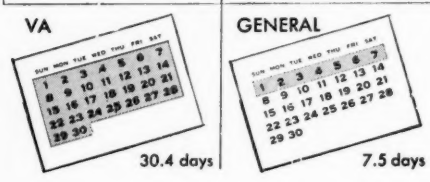
The Fifth Annual Scientific Assembly of the Florida Academy of General Practice will convene at the San Juan Hotel in Orlando on Sunday, Oct. 17, 1954, at 1 p.m. and will continue through Monday, October 18. The excellent program, while planned primarily for general practitioners, should have wide appeal and is open to all physicians of the state, whatever their specialty. There is no registration fee. Some 30 leading drug and surgical firms will have exhibits. The Orange County Chapter of the Academy is sponsoring the meeting, an important feature of which will be the banquet at 8 p.m. on Sunday night.

Among the distinguished guest speakers are the Deans of Florida's medical schools, who will explain what the general practitioner should expect of and can contribute to medical education in Florida. The lecturers are: Dr. George T. Harrell Jr., Dean and Professor of Medicine, College of Medicine, University of Florida, Gainesville; former Dean Robert T. Spicer, University of Miami School of Medicine, Miami; Dr. Jack F. Schaber, Cardiologist, Orlando; Dr. Robert W. Curry, Radiologist, Orange Memorial Hospital, Orlando; Dr. Joseph B. Miller, Pediatrician, Mobile, Ala.; Dr. Fred Mathers, Chief of Medicine, Orange Memorial Hospital, Orlando; Dr. W. Ansell Derrick, Pathologist, Orange Memorial Hospital, Orlando; Dr. Robert P. Walton, Professor of Pharmacology, Medical College of South Carolina, Charleston, S. C., and author of the National Board questions; Dr. Sullivan G. Bedell, Psychiatrist, Jacksonville; Dr. Herbert A. King, Chief of the Medical Service, Halifax District Hospital, Daytona Beach; Dr. John E. Peterson, Professor of Medicine, College of Medical Evangelists, Los Angeles, Calif.; Dr. Milton S. Saslaw, Director of Medical Research, National Children's Cardiac Hospital, Miami; Dr. Francis H. Cole, Chief of the Surgical Service, West Tennessee Hospital of Chest Diseases, Memphis, Tenn.; Dr. Jack Glassman, former Professor of Surgery, Cook County Hospital Postgraduate School, Chicago; and Dr. Hawley H. Seiler, Chief of Thoracic Surgery, Southwest Florida Tuberculosis Hospital and Tampa Municipal Hospital, Tampa.

The program for the two day meeting appears on the opposite page.

In Viewing the VA Medical Program . . .

comparison of length of stay in VA and general hospitals
GM&S



General medical and surgical patients in VA hospitals are confined four times longer than in non-federal hospitals. VA hospitals admit patients for examination, diagnosis, and treatment, much of which is normally undertaken outside civilian hospitals. Also, VA patients often remain hospitalized throughout the entire medical treatment period, whereas non-VA patients are usually treated at home during their convalescence. This is a major factor in the tremendous cost of the VA medical program.

L. Paul Foster, M.D., Editor
Florida Newsletter
Florida Academy of General Practice
1221 North Orange Avenue
Orlando, Florida

I plan to attend the Fifth Annual Scientific Assembly of the Florida Academy of General Practice at the San Juan Hotel in Orlando, October 17-18, 1954.

....., M.D.

PROGRAM
FIFTH ANNUAL SCIENTIFIC ASSEMBLY
FLORIDA ACADEMY OF GENERAL PRACTICE
SAN JUAN HOTEL, ORLANDO

SUNDAY, OCTOBER 17

12:00- 1:00	Registration and Exhibits	
1:00- 2:00	Welcome to the Assembly	
	Dr. Leonard L. Weil, President,	
	Florida Academy of General Practice	
	Dr. Duncan T. McEwan, President,	
	Florida Medical Association	
	"Postgraduate Education of the Family Doctor"	Dr. Spicer
2:00 -2:30	"Advances in Postoperative Care"	Dr. Glassman
2:30 -3:00	"Problems in Diagnosis of Thyroid Disease"	Dr. Peterson
3:00 -3:30	Recess for Exhibits	
3:30 -4:00	"Present Day Tuberculosis Therapy"	Dr. Seiler
4:00- 4:30	"Pitfalls in Diagnosis of Lung Diseases"	Dr. Cole
4:30 -5:00	"Use of Aerosols in Respiratory Diseases"	Dr. Miller
8:00	Banquet	

MONDAY, OCTOBER 18

8:30 -9:00	Registration and Exhibits	
9:00- 9:30	"Congenital and Rheumatic Heart Disease in Children"	Dr. Saslaw
9:30-10:00	"Diagnosis and Treatment of Cardiac Emergencies"	Dr. Schaber
10:00-10:30	"Recent Views of Drugs Used in Heart Dysfunction"	Dr. Walton
10:30-11:00	Recess for Exhibits	
11:00-11:30	"Psychotic Reactions in the Geriatric Patient"	Dr. Bedell
11:30-12:00	"Medical Emergencies"	Dr. Peterson
12:00- 1:00	Luncheon	
1:00- 1:30	"The Diagnosis and Treatment of Common Hematological Problems"	Dr. King
1:30- 2:00	"Radioactive Isotopes"	Dr. Curry
2:00- 2:30	"Chemotherapy in Malignant Diseases"	Dr. Mathers
2:30- 3:00	Recess for Exhibits	
3:00- 4:00	"The Place of the General Practitioner in Medical Education"	Dr. Harrell
4:00- 5:00	Clinicopathologic Conference	Dr. Derrick
5:00- 5:30	"Cholecystitis"	Dr. Glassman

Course in Electrocardiography National Children's Cardiac Hospital Miami, Sept. 20-25, 1954

"Modern Concepts of Electrocardiography" is the title of a course to be conducted by Dr. Demetrio Sodi-Pallares, head of the Department of Electrocardiography, Instituto Nacional de Cardiologia, Mexico, at the National Children's Cardiac Hospital in Miami this month. The course will open on Monday, September 20, and will continue through Friday, September 25, from 9 a.m. to 1 p.m. in the hospital's auditorium.

The program follows:

1. Electrophysiology
   (1) Theory of the dipole
   (2) Cellular polarization and reversed polarization
   (3) Experiments of Cole and Curtis
   (4) Unipolar and bipolar leads
   (5) Electrical field of the heart
2. Activation of the Normal Heart
   (1) Cardiac vectors
   (2) Auricular activation
   (3) Activation of the interventricular septum
   (4) Activation of the free ventricular walls
3. Auricular and Ventricular Enlargement
   (1) Different types of right and left ventricular enlargement
   (2) Mechanism of production of the electrocardiographic changes
4. Bundle Branch Block
   (1) Mechanism of production of the electrocardiographic changes
   (2) Different degrees of bundle branch block; its clinical significance
   (3) Bundle branch block versus focal block
   (4) Bundle branch block versus ventricular aberrant response
5. Electrocardiographic Changes in Coronary Blood Flow Disturbances
   (1) Muscle injury
   (2) Ischemic muscle
   (3) Dead muscle
   (4) Localization of myocardial infarction
   (5) Evolution of myocardial infarction
6. Electrocardiographic Patterns in Congenital Heart Disease
   Wolff-Parkinson-White Syndrome

Dr. Sodi-Pallares urges participants to bring in all of their unusual electrocardiograms for his evaluation and general discussion. Sessions will be held informally, and questions will be welcomed.

The cost of the course is $20. Since attendance is limited, it is suggested that all those interested apply at once, sending their check payable to the National Children's Cardiac Hospital, 4250 West Flagler St., Miami 34.

Tri-State Obstetric Seminar

The Tri-State Obstetric Seminar sponsored locally by the Maternal Welfare Committee of the Florida Medical Association and the Bureau of Maternal and Child Health of the Florida State Board of Health will be held again in the Daytona Plaza Hotel in Daytona Beach on September 13, 14 and 15. This Seminar now in its fourth year is becoming increasingly popular and will feature nationally known figures in the fields of obstetrics and pediatrics. The first day has been designated as Pediatric Day. The remaining days will be devoted to problems of particular interest to obstetricians and general practitioners. There is no registration fee and those attending should make their own hotel reservations.

Graduate Medical Education

The Twenty-Second Annual Graduate Short Course for doctors of medicine was held at the George Washington Hotel in Jacksonville July 12-16, 1954. The total paid registration was slightly over 10 per cent greater than last year. The interest manifested by those in attendance evidenced the type of lectures given. The series of lectures was planned primarily for the general practitioner, but constituted an excellent review and in addition presented the latest developments in medicine and surgery. Though many who attended expressed regret that the Short Course had to be held three weeks later than usual, it could not be avoided because of the annual meeting of the American Medical Association the last week in June. If a similar conflict does not occur next

year, this course will be held the last week in June as has been the custom since the beginning of the Short Course.

The Committee on Medical Postgraduate Course was particularly pleased to have the lectures on medicine given by Dr. George T. Harrell Jr., Dean and Professor of Medicine of the College of Medicine of the University of Florida. The reception given for Dr. and Mrs. Harrell at the cocktail hour on Wednesday, July 14, was well attended and afforded many Florida physicians the opportunity of meeting Dr. Harrell.

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The program for the second annual meeting of the Florida Clinical Diabetes Association in Orlando on October 21 and 22 was published in the August issue of The Journal. Guest lecturers, who are well known to many physicians of Florida, are Dr. H. B. Mulholland and Dr. Joseph T. Beardwood Jr. Any member of the Florida Medical Association, after paying a small registration fee, is eligible to attend the two day session without the necessity of joining the Diabetes Association.

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Plans for the course in Hematology, to be held in Jacksonville at the George Washington Hotel on November 18-20, have been completed. The detailed program will be published in The Journal. Programs will also be mailed to all physicians in Florida. The faculty will consist of Dr. William Dameshek, Director, Blood Research Laboratory, New England Center Hospital, Boston, Dr. Z. Komninos, Boston, his assistant, and Dr. James N. Patterson, Tampa. Only certified laboratory technicians or those presenting special requests from hospitals, private physicians or Boards of Health will be admitted to this course. The registration fee for physicians is $25 and for technicians $15. Advance registrations are requested.

OTHERS ARE SAYING

"M.D." — Not "Dr."

In these years when more and more individuals are earning degrees of Doctor of Chiropractic, Doctor of Osteopathy, Doctor of Philosophy, Doctor of Divinity, Doctor of Dental Surgery and Doctor of Medicine — not to mention the dozens of unearned honorary doctorates — the term "Doctor" or "Dr." is fast losing its meaning and significance. The medical profession must retain its identity and individuality, but cannot unless physicians themselves discontinue using the term "Doctor" whenever and wherever possible.

Physicians, upon graduation, are awarded the degree which is officially abbreviated "M.D." Let's remember that we are M.D.'s and let's use our degree to identify ourselves whenever our names appear in print or in writing. On professional cards, signs on office doors and windows, stationery, announcements, prescription blanks, yes, everywhere, have your name printed with the M.D.; sign your name with the M.D. People will then know that you are a physician, not a Ph.D., anything-else-D., or what have you.

Remember, also, to say "physician" or "surgeon" whenever possible in conversation, and you will be surprised how seldom it is necessary to say "Doctor." Our prestige will be enhanced as members of the medical profession if we will follow these suggestions.

—Contributed From Montana.
—*Rocky Mountain Medical Journal, May 1954*

R, E, and S

By Basil E. Barton, M.D., President

(The Norfolk District of the Massachusetts Medical Society)

It has become almost a cliche to compare medicine to a three-legged stool, which cannot stand unless all the legs are intact. The legs are called *Research, Education,* and *Service.* The first, being the most dramatic, receives the bulk of philanthropy. The second, in the opinion of the medical school deans, suffers correspondingly. The third is said to be not as good as it might be because practitioners are slow in giving their

patients the Service which Research and Education have made available. In short everyone is dissatisfied.

It was a pleasant surprise, therefore, to run across a second trilogy which bears the initials R, E, and S, but which differs from the other in being a sure-fire formula for happiness. It appears in a small, out-of-print book titled, of all things, "Talks to Freshman Girls" and written by Helen Brown for Vassar students. By thinking back over recent months one will see that it could have been as valuable a motto for a medical society as for a freshman girl. The R is for *Religion,* which for our purpose means the Golden Rule. E is again for *Education,* which in Society meetings is often gained the hard way. S is for a *Sense of Humor,* lack of which can make one look not a little ridiculous.

It will be a lot easier this year if we do unto others as we would be done by, having first tried to educate ourselves to the other person's point of view, and finally take seriously our jobs but not ourselves.

—*Norfolk Medical News, May 1954*

En Route

In a drive just completed to the West Coast, we were interested in conversations which we overheard.

At a restaurant in Arizona we were intrigued by two men whom we would judge to be in their forties — rather small of stature, quick, alert — of the terrier type. They attacked medicine and each incited and excited the other. They finally came to the conclusion that a doctor of medicine had to, at all times, respond at once to calls and that he should not be allowed to exercise his judgment as to the urgency of the calls or to take into account his own commitments or his own physical state. They left the restaurant in self-worked-up high dudgeon, bristling with indignation and ready to set upon and tree any hapless doctor who might come by.

We were interested in signs on homes advertising osteopath, chiropractor, and Swedish massage (apparently they do not dare use the word masseur), and at one home we saw the sign, "Herbalist." We inferred that someone was advertising himself as proficient in the medical use of herbs. We have never seen the word before. Maybe this marks the birth of a new cult — something to revivify and formalize what the old styled Indian doctors did.

But, never did we hear the cults berated as to responding to calls. Maybe they always respond because they are not overworked. It is our contention that the public has not been trained to a hostile attitude toward the cults — whereas they have for twenty years been bitterly conditioned against us — government press, franking privileges and injunctions against our own efforts to fight for our own rights. Why? Not because we are or have been bad — but because state medicine would be the keystone of the arch of a socialized state.

Numerous conversations overheard along the way brought us startlingly face to face with the fact that this hostile attitude is not limited to one section of the country but is wide-spread over the nation. It is here — whether it is our fault or not. We should do something about it. At the risk of being repetitious we would say that all doctors should begin enlightening their patients and other friends before an irreparable cleavage takes place.

F. T. H'Doubler, M.D.
—*Missouri Medicine, May 1954*

BIRTHS AND DEATHS

Births

Dr. and Mrs. Matthew A. Larkin of Miami announce the birth of a daughter, Catherine Ruth, on July 10, 1954.

Dr. and Mrs. J. K. David Jr. of Jacksonville announce the birth of a daughter, Barbara Najibah, on July 13, 1954.

Dr. and Mrs. Clyde M. Collins of Jacksonville announce the birth of a son, Clyde Mabry Jr., on July 16, 1954.

Deaths — Members

Lowe, Eugene C., Miami ..... July 2, 1954
Miller, George E., St. Petersburg ..... July 14, 1954

Deaths — Other Doctors

Davis, James D. (Col.), Tampa ..... June 6, 1954
Robles, Charles W., Tampa ..... June 18, 1954
Teagarden, Elmer J., Apopka ..... July 20, 1954

Medical Officers Returned

Dr. Charles K. Donegan, who entered military service on May 15, 1953, was released from active duty on June 13, 1954, with the rank of lieutenant commander, U. S. Navy. His address is 501 11th St., North, St. Petersburg.

SEE YOU IN MIAMI . . .

Eighth A.M.A. Clinical Session

November 29-December 2, 1954

The 8th A.M.A. Clinical Meeting in Miami will feature a related, balanced program of lectures and clinical conferences. Attention will be focused upon the diseases and conditions most frequently met by the General Practitioner.

Registration will begin at 8:30 a.m., Monday, November 29. The meeting will close each evening at 5:30 p.m., and Thursday, December 2, at noon. The morning and afternoon programs will consist of general meetings, clinical conferences and coordinated sessions. The main subjects on the program are: Neurology and Psychiatry, Arthritis, Dermatology, Gastrointestinal Diseases, Pediatrics, Obstetrics and Gynecology, Pulmonary Diseases, Orthopedics, Surgery.

Plan now for your attendance at this important meeting. There will be ample opportunity for discussion of your problems with demonstrators in Scientific Exhibits, which amplify new treatments and technics. America's leading firms will be represented in the Technical Exhibits to present modern and efficient equipment to better supply the General Practitioner.

STATE NEWS ITEMS

The largest group of physicians ever to seek admittance to practice medicine in Florida took examinations before the Florida State Board of Medical Examiners in Jacksonville, June 27-29, 1954. Dr. Homer L. Pearson Jr. of Miami, secretary of the board, said that 358 took the examination at that time; the largest previous number was 280. The list of successful applicants will be published in a later issue of The Journal.

Dr. Winston L. Summerlin of Gainesville has returned to his practice from a nine month teaching and postgraduate study tour at the Tulane University of Louisiana School of Medicine.

Dr. John F. Lovejoy of Jacksonville was invited to be the guest of Dr. A. R. Shands, president of the American Orthopedic Association, at the organization's annual meeting in Bretton Woods, N. H.

Dr. Ralph S. Sappenfield of Miami has been elected chairman of the section on anesthesiology of the American Medical Association.

Dr. Rodes C. Garby of St. Petersburg has been elected president of the Pinellas County Tuberculosis and Health Association.

Dr. Carl M. Pults of Lake Worth was installed as president of the Rotary Club on June 29.

Drs. Joseph B. Ganey and Richard V. Meaney of Bradenton spoke on two viewpoints on the use of the X-ray in medical pathology at a luncheon meeting of the Rotary Club of that city on June 22.

Dr. William C. Hutchison of Hialeah spoke at a meeting of the Upper Keys Kiwanis Club on July 2. His subject was lung cancer.

Dr. Floyd K. Hurt of Jacksonville took a two week postgraduate course in pediatric roentgenology in Boston in May.

Dr. Morton M. Halpern of Miami was installed as president of the Heart Association of Greater Miami on June 17. Dr. Robert V. Edwards of South Miami was installed as vice president, and Dr. Jim S. Jewett of Coral Gables, secretary. Dr. Paul N. Unger of Miami Beach was chosen president-elect.

Dr. J. K. David Jr. of Jacksonville spoke on "Blood Values of the Newborn Including Discussion of Rh Factor," at the regular monthly meeting of the Duval County Academy of General Practice on July 27.

Dr. Charles A. Schwarz of Miami Shores entered medical service with the U. S. Army on July 1, 1954, with the rank of captain.

Dr. Joshua C. Dickinson of Tampa, president-elect of the American Roentgen Ray Society, will be installed as president and will deliver his Inaugural Address on September 21 at the opening session of the Fifty-Fifth Annual Meeting of the Society. The meeting, which will be held at the Shoreham Hotel, Washington, D. C., will continue through September 24.

Dr. Raney A. Oven of Tallahassee took a course on polio care in Houston, Tex., in July.

Dr. Leo M. Levin of Miami Beach was installed as president of the Miami Phi Delta Epsilon chapter at the medical fraternity's annual installation dinner-dance on July 17. Other officers installed were: Drs. William Wickman, Miami, vice president; Jesse O. Halpern, secretary; Richard D. Shapiro, treasurer; Stanley E. Schwartz, sergeant-at-arms; Maurice J. Rose, senator; Victor Kugel, alternate senator, and Maurice Zimmerman, historian, all of Miami Beach.

Keys denoting a quarter century of service to the medical profession were presented to Drs. Max Pepper, Miami, and Maurice I. Edelman and Julius R. Pearson, Miami Beach.

Dr. Wade S. Rizk of Jacksonvile attended the Silver Jubilee commemorating the twenty-fifth anniversary of his graduation class at Georgetown University, Washington, D. C., on June 5 and 6.

Dr. Rizk gave a talk on "The Contribution of X-Rays to Medicine" at a meeting of the Southside Kiwanis Club on June 24.

Dr. Paul J. McCloskey of Tampa was awarded a prize for his "outstanding contribution" to the Greater Tampa Chamber of Commerce on July 14.

Drs. Paul N. Unger of Miami Beach and Scheffel H. Wright of Miami are co-chairmen of a committee of the Heart Association of Greater Miami on community service. The committee will give special attention this year to a program of job placement for persons handicapped by cardiovascular ailments.

Dr. Joseph H. Lucinian of Miami announces the association of Dr. Carlos G. Llanes for the practice of general radiology.

The American College of Chest Physicians held its Twentieth Annual Meeting in San Francisco, June 17-20. Dr. M. Jay Flipse of Miami is Regent for this District, and Dr. Arnold S. Anderson of St. Petersburg serves as Governor of the College for Florida.

Dr. Ralph J. Greene of Perry recently celebrated the fortieth anniversary of the establishment of his practice in Taylor County. It is estimated that Dr. Greene has attended at the birth of over 1,000 babies during his years of service.

Dr. L. H. Paul of Bonifay was honored on August 1 for 46 years of medical service to the community. Several hundred residents of Holmes County gathered at Memorial Field to pay homage to Dr. Paul. The day was proclaimed "Dr. Paul Day," and many of the "babies" which he delivered were present for the celebration.

Dr. Sidney Halpern of Jacksonville is a vice president of the newly-formed civic club, The Certoma Club, and Dr. Aaron Z. Oberdorfer is a committee chairman.

Dr. George L. Emmel of Gainesville addressed the health education section of the State Home Demonstration Short Course at the University of Florida on July 14. Members of home demonstration clubs from throughout Florida were on the campus for the course which was scheduled for the entire week. The activities were part of the Rural Health Program of the Florida Medical Association, Florida Agricultural Extension Service, Florida State Board of Health and the Florida Farm Bureau.

Dr. Joseph Canipelli of Jacksonville gave a talk on "Cancer of the Body" at a meeting of the Christian Women's Fellowship, Riverside Avenue Christian Church, in May.

Dr. Hugh A. Carithers of Jacksonville attended a meeting of the Committee on Foetus and Newborn of The American Academy of Pediatrics in Washington in June.

Dr. James F. Speers of Titusville has returned to his position as head of the Brevard and Osceola County Health Departments after a year's leave of absence. Dr. Speers has been taking graduate work at the University of North Carolina.

Dr. Oscar L. Kelley of Palm Beach is chairman of a committee to study and design the program to be followed by the Heart Clinic of Palm Beach County. Members of the committee include Drs. Clarence L. Brumback, Saul D. Rotter and Ralph M. Overstreet Jr., of West Palm Beach; Drs. Wm. E. Van Landingham and Alvin E. Murphy, of Palm Beach; and Dr. Sidney Davidson of Lake Worth.

Dr. Turner Z. Cason of Jacksonville is a director of the Council of Social Agencies for the next three years.

Dr. Gary E. Turner of Jacksonville took part in a television panel in May on "The Importance of Early Recognition of Mental Illness."

Dr. Lorenzo L. Parks of Jacksonville spoke at a meeting of the Confederate Flag Chapter, United Daughters of the Confederacy, in May. His subject was a "Review of Medical Service During the War Between the States."

Dr. Dorothy D. Brame of Orlando attended the International Congress of Obstetrics and Gynecology in Geneva, Switzerland.

Drs. Whitman C. McConnell of St. Petersburg and Russell B. Carson of Fort Lauderdale were recent visitors at the Association's office in Jacksonville.

Dr. Ray O. Edwards Jr. of Jacksonville talked on "Preparing Your Child for School" at the Hyde Park School summer round-up.

Dr. A. Judson Graves of Jacksonville gave the opening address at the annual meeting of the Florida Society of X-Ray Technicians held in Miami in May.

Dr. Meredith F. Campbell of Miami spoke before the Cuban National Pediatric Society on July 17 in Havana, Cuba. His subject was the indications for urologic examination in infants and children.

Dr. Andrew G. Brown of Miami has been appointed a member of the Florida State Board of Medical Examiners, according to announcement by the Governor's office.

Dr. Gunnard J. Antell of Coral Gables presented a paper on "Pediatric Tools in the Evaluation of Growth and Development" before the Aereal Meeting of the Finnish Pediatric Society in Helsinki and the Danish Pediatric Association in Copenhagen in July.

Dr. William Wickman of Miami spoke on "Certain Aspects of Gall Bladder Disease," at the June 16 staff meeting of the Edgewater Hospital.

Dr. Ira K. Brandt of Coral Gables spoke on nephrosis at an open meeting of Coral Gables Lodge No. 173, Knights of Pythias on July 22.

Dr. N. Worth Gable of St. Petersburg has returned to his practice after Reserve duty tour at Fort McClellan, Ala.

Dr. Irby H. Black of Live Oak attended the Southeastern Medical Seminar in Saluda, N. C., July 25-31.

COMPONENT SOCIETY NOTES

Bay

The Bay County Medical Society has paid 100 per cent of its state dues for 1954.

Dade

At the regular monthly meeting of the Dade County Medical Association on August 3, Drs. Martin G. Gould and Donald W. Smith spoke on "Blood Transfusions with Special Reference to Use of Plasma and Plasma Expanders."

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Appleby, Leonard W., Lake Worth
Baker, Roy M., Jacksonville
Colbert, Walter T., Pensacola
Davis, Robert J., Tampa
Emlet, John R., Pensacola
Gillespie, Samuel D. Jr., Pensacola
McPherson, A. Ziegler, Tampa
Park, Charles L. Jr., Sanford

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

FOR SALE: Equipment and Practice. Excellent location with good lease. Active General Practice, Sarasota, Fla. Write 69-127, P.O. Box 1018, Jacksonville, Fla.

GENERAL PRACTITIONER: Wanted, Lake Butler, Fla. Population 1,100, farming community. No physicians at present. Modern clinic building and equipment available rent free. Write Mr. Robert A. Driggers, Clerk of Circuit Court, Lake Butler, Fla.

FOR SALE: 24 bed hospital, fully equipped in full operation. Owner wishes less work. Write 69-128, P. O. Box 1018, Jacksonville, Fla.

GENERAL PRACTICE: Six years' duration, grossing $35,000 yearly; available on easy terms (pay as you go). Imperative you act quickly. Write 69-129, P. O. Box 1018, Jacksonville, Fla.

DERMATOLOGIST: Desires full, or part-time office association. Board eligible. Especially qualified skin pathologist. Florida license. Priority IV, age 37, married. Available October 1. Write 69-130, P.O. 1018, Jacksonville, Fla.

Dramamine's® Effect in Vertigo

Dramamine has become accepted in the control of a variety of clinical conditions characterized by vertigo and is recognized as a standard for the management of motion sickness.

Vertigo, according to Swartout, is primarily due* to a disturbance of those organs of the body that are responsible for body balance. When the posture of the head is changed, the gelatinous substance in the semi-circular canals begins to flow. This flow initiates neural impulses which are transmitted to the vestibular nuclei. From this point impulses are sent to different parts of the body to cause the symptom complex of vertigo.

Some impulses reach the eye muscles and cause nystagmus; some reach the cerebellum and skeletal muscles and righting of the head results; others activate the emetic center to result in nausea, while still others reach the cerebrum making the person aware of his disturbed equilibrium. *Vertigo may be caused by a disease or abnormal stimuli of any of these tissues involved in the transmission of the vertigo impulse, including the cerebellum and the end organs.*

A possible explanation of Dramamine's action is that it depresses the overstimulated labyrinthine structure of the inner ear. Depression, therefore, takes place at the point at which these impulses, causing vertigo, nausea and similar disturbances, originate. Some investigators have suggested that Dramamine may have an additional sedative effect on the central nervous system.

Repeated clinical studies have established Dramamine as valuable in the control of the symptoms of Ménière's syndrome, the nausea and vomiting of pregnancy, radiation sickness, hypertension vertigo, the vertigo of fenestration procedures, labyrinthitis and vestibular dysfunction associated with antibiotic therapy, as well as in motion sickness.

Any of these conditions in which Dramamine is effective may be classed as "disease or abnormal stimuli"* of the tissues including the end organs (gastrointestinal tract, eyes) and their nerve pathways to the labyrinth.

Dramamine (brand of dimenhydrinate) is supplied in tablets of 50 mg. and liquid (12.5 mg. in each 4 cc.). It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

The site of Dramamine's action is probably in the labyrinthine structure.

*Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP *8*:35 (Nov.) 1953.

WOMAN'S AUXILIARY
TO THE
FLORIDA MEDICAL ASSOCIATION

OFFICERS

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MRS. SAMUEL S. LOMBARDO, President-elect....*Jacksonville*
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Fall Begins Busy Season for Florida Auxiliary

At the time of this writing, plans for the fall and winter season activities of the Woman's Auxiliary to the Florida Medical Association are becoming advanced, and we are looking forward not only to a busy but to a profitable eight months until the time of our next meeting in St. Petersburg, April 3-6, 1955.

The midyear Board Meeting and Conference of County Presidents and Presidents-elect will be held in St. Petersburg at the Tides Hotel on Sept. 21-22, 1954. This meeting is being looked forward to by the officers, chairmen and the county presidents, presidents-elect and/or vice presidents. The meeting will open with a conference for chairmen and county personnel at 2:30 p.m. on Tuesday, September 21. Mrs. Samuel S. Lombardo, President-elect of the Florida Auxiliary, is in charge of this conference and will be the presiding officer. Mrs. Lombardo is planning an excellent program and it is hoped that we shall have 100 per cent attendance from the county auxiliaries.

The Executive Board Meeting will be held the following morning at 9:30 a.m., and the business of the Auxiliary will be attended to at this meeting.

Not forgetting the social side and fellowship of such meetings, a dinner will be held on the evening of September 21. Entertainment is to be announced. At the noon hour on September 22, a luncheon will be held. The fun and social hours of the Auxiliary mean much in our contacts with each other.

During this meeting, county presidents will present plans for their auxiliaries and we shall attempt to learn from each other.

The District Workshops to be held at the District Meetings of the Florida Medical Association are being planned by our vice presidents, who are in charge of the programs and will preside at these meetings. Mrs. William D. Rogers will be in charge of the meeting in District A on October 11; Mrs. Albert G. Love IV, District B, October 13; Mrs. John P. Ferrell, District C., October 15; and Mrs. Charles McD. Harris Jr., District D, October 14. We are looking for a big turnout for these meetings from the auxiliaries and counties in each district.

In November, representation from Florida will be present in St. Louis for the Southern Medical Association and Auxiliary meetings. Mrs. Lee Rogers Jr., Cocoa, is the councilor for the auxiliary from Florida; Mrs. Perry D. Melvin, Miami, is the chairman of the Jane Todd Crawford Memorial Loan Fund, and Mrs. Richard F. Stover, Miami, is chairman of revisions for this organization. Meetings of the Southern Auxiliary will be held in the Statler Hotel, St. Louis, November 8-11. Many other women from Florida are planning to attend.

Also, from November 16 through 18, Mrs. Samuel S. Lombardo, President-elect, and Mrs. Richard F. Stover, President, of the Florida Auxiliary will attend the annual Conference of State Presidents, Presidents-elect and National Committee Chairmen at the Drake Hotel in Chicago. This conference takes the place of a mid-interim meeting for the national auxiliary.

The Clinical Session of the A.M.A. is to be held in Miami this year November 28-December 2, and many of the auxiliary members from Florida will be present with their husbands, though no official auxiliary meetings take place at this time.

All these meetings, though important, do not take the place of the importance of the work of the local auxiliary, for it is through them that our projects are advanced. In between meetings, the members of the Florida Auxiliary will have started their work on our projects and we will see them advancing all through this year. The wives of Florida doctors are busy at their tasks of advancing health education, aiding the medical associations and societies, learning more how to do the job and serving the health needs in their communities. The Woman's Auxiliary to the Florida Medical Association takes off its hat to its members who do such an excellent work throughout the year.

Mrs. Richard F. Stover, President

Florida Takes Sunshine of Her Smiles to San Francisco Convention

Standing left to right: Mrs. Edward F. Fox, Mrs. Donald F. Marion, Dade County; Mrs. Francis D. Pierce, Mrs. eorge T. F. Rahilly, Broward County; Mrs. John M. Butcher, Sarasota County; Mrs. V. Marklin Johnson, Palm each County; Mrs. Randolph Shevach, Mrs. Milton M. Coplan, Dade County.

Seated left to right: Mrs. Frederick P. Poppe, Dade County; Mrs. Burns A. Dobbins Jr., Broward County; Mrs. ichard F. Stover, Dade County; Mrs. James N. Patterson, Hillsborough County; Mrs. John R. Ramey, Dade County.

Present and smiling but not in picture: Mrs. Sullivan G. Bedell, Mrs. John H. Mitchell, Duval County; Mrs. Jack Q. leveland, Mrs. R. Spencer Howell, Mrs. Paul S. Jarrett and Mrs. William C. Phillips, Dade County.

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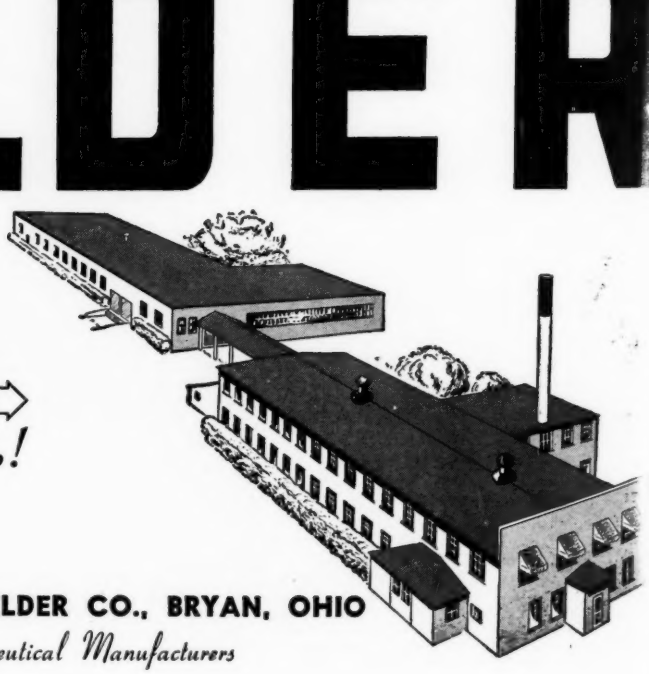

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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Duncan T. McEwan, Orlando	Samuel M. Day, Jacksonville	St. Petersburg, Apr. 3-6, '55
Florida Medical Districts	Francis H. Langley, St. Petersburg	Council Chairman	
A-Northwest	William H. Hixon, Pensacola	George S. Palmer, Tallahassee	Marianna, Oct. 11, '54
B-Northeast	Henry J. Babers Jr., Gainesville	Thomas C. Kenaston, Cocoa	Sanford, Oct. 13, '54
C-Southwest	Clyde O. Anderson, St. Petersburg	James R. Boulware Jr., Lakeland	Sarasota, Oct. 15, '54
D-Southeast	James R. Sory, West Palm Beach	Russell B. Carson, Ft. Lauderdale	Vero Beach, Oct. 14, '54
Florida Specialty Societies			
Academy of General Practice	Leonard L. Weil, Miami Beach	Leon S. Eisenman, Hialeah	St. Petersburg, Apr. 3, '55
Allergy Society	Solomon D. Klotz, Orlando	Edwin P. Preston, Miami	" "
Anesthesiologists, Soc. of	R. Gaylord Lewis, West Palm Beach	Harry E. Bierley, West Palm Beach	" "
Chest Phys., Am. Coll., Fla. Chap.	DeWitt C. Daughtry, Miami	Jack Reiss, Coral Gables	" "
Derm. and Syph., Soc. of	Hollis F. Garrard, Miami	Joseph A. J. Farrington, Jacksonville	" "
Health Officers' Society	Thomas E. Morgan, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
Industrial and Railway Surgeons	Plumer J. Manson, Miami	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	Sullivan G. Bedell, Jacksonville	Roger E. Phillips, Orlando	" "
Ob. and Gynec. Society	Harold G. Nix,Tampa	Reuben B. Chrisman Jr., Miami	" "
Ophthal. & Otol., Soc. of	G. Tayloe Gwathmey, Orlando	Carl S. McLemore, Orlando	" "
Orthopedic Society	John F. Lovejoy, Jacksonville	Newton C. McCollough, Orlando	" "
Pathologists, Society of	Millard B. White, Sarasota	James B. Leonard, Tampa	" "
Pediatric Society	C. Jennings Derrick, W. Palm Bch.	Wesley S. Nock, Coral Gables	St. Petersburg Bch., Oct. 22-24, '54
Proctologic Society	Claude G. Mentzer, Miami	George Williams Jr., Miami	St. Petersburg, Apr. 3, '55
Radiological Society	A. Judson Graves, Jacksonville	James T. Shelden, Lakeland	" "
Surgeons, Am. Coll., Fla. Chapter	Frederick J. Waas, Jacksonville	C. Frank Chunn, Tampa	" "
Urological Society	Linus W. Hewit, Tampa	Frank J. Pyle, Orlando	" "
Florida—			
Basic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 6, '54
Blood Banks, Association	John T. Stage, Jacksonville	John B. Ross, Jacksonville	St. Petersburg, 1955
Blue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Palm Beach Shores, Nov. 17, '54
Blue Shield of Florida, Inc.	David R. Murphey Jr., Tampa	Jack O. W. Rash, Miami	
Cancer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	St. Petersburg, Apr. 3, '55
Clinical Diabetes Assn.	Fred Mathers, Orlando	Edward R. Smith, Jacksonville	Orlando, Oct. 21-22, '54
Dental Society, State	Robt. Thoburn, D.D.S.,Daytona Bch	J. E. Edwards, D.D.S., Coral Gables	Jacksonville, Apr. 23-25, '55
Heart Association	Alvin E. Murphy, Palm Beach	Daniel R. Usdin, Jacksonville	April 1955
Hospital Association	Mr. J. F. Wymer Jr., W. Palm B.	Mrs. Mary Reeder, Miami	
Medical Examining Board	Frank D. Gray, Orlando	Homer L. Pearson Jr., Miami	Jacksonville, Nov. 21-23, '54
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Nurse Anesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lulla F. Bryan, Miami	Palm Bch. Shores, Nov. 17-19, '54
Nurses Association, State	Mrs. Bertha King, Tampa	Mrs. Idalyn Lawthon, Tampa	Jacksonville, Oct. 30-Nov. 3, '54
Pharmaceutical Association, State	Mr. J. L. McDonald, St. Augustine	Mr. R. Q. Richards, Ft. Myers	Clearwater, May '55
Public Health Association	Frank M. Hall, Gainesville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, Oct. 21-23, '54
Trudeau Society	Lawrence C. Manni, Tallahassee	Simon D. Doff, Jacksonville	May, 1955
Tuberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mrs. L. C. Conant, Fort Myers	
Woman's Auxiliary	Mrs. Richard F. Stover, Miami	Mrs. S. J. Wilson, Ft. Lauderdale	St. Petersburg, Apr. 3, '55
American Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, '55
A.M.A. Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Miami, Nov. 29-Dec. 2, '54
Southern Medical Association	Alphonse McMahon, St. Louis	Mr. C. P. Loranz, Birmingham	St. Louis, Nov. 8-11, '54
Alabama Medical Association	J. M. Donald, Birmingham	Douglas L. Cannon, Montgomery	Montgomery, Apr. 21-23, '55
Georgia, Medical Assn. of	Peter B. Wright, Augusta	David Henry Poer, Atlanta	Augusta, May 1-4, '55
S.E. Hospital Conference	Mr. John W. Gill, Vicksburg, Miss.	Mr. Pat Groner, Pensacola	Atlanta, Apr. 20-22, '55
Southeastern Allergy Assn.	W. L. Rucks, Memphis, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Orlando, 1955
Southeastern, Am. Urological Assn.	Sam L. Raines, Memphis, Tenn.	Robert F. Sharp, New Orleans	New Orleans Mar. 20-23, '55
Southeastern Surgical Congress	J. Duffy Hancock, Louisville, Ky.	B. T. Beasley, Atlanta	Atlanta, Mar. 7-10, '55
Gulf Coast Clinical Society	Jas. N. Lockard, Pascagoula, Miss.	F. C. Minkler, Pascagoula, Miss.	Edgewater Park, Miss., Oct. 21-22,

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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Henry H. Graham, Gainesville	Glenn O. Summerlin, Gainesville	2nd Tues.	51
******Bradford, Gilchrist, Union*				
Bay	Lemuel F. Coxe Jr., Panama City	James D. Nixon, Panama City	1st Tues.	26
Brevard	Theodore J. Kaminski, Melbourne	Paul L. Summers, Melbourne	2nd Tues.	28
Broward	Julius F. Boettner, Fort Lauderdale	George T. F. Rahilly, Fort Lauderdale	4th Tues.	108
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	12
******Baker, Hamilton*				
Dade	Edward W. Cullipher, Miami	Kenneth S. Whitmer, Miami	1st Tues.	668
DeSoto-Hardee-Highland-Glades	Carl J. Larsen, Avon Park	Samuel A. King, Avon Park	2nd Tues.	27
Duval	Karl B. Hanson, Jacksonville	Jackson L. Allgood Jr., Jacksonville	1st Tues.	273
******Clay*				
Escambia	Wilton E. Tugwell, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	100
******Santa Rosa*				
Franklin-Gulf	Albert L. Ward, Port St. Joe	Warren T. Weathington, Apalachicola	Last Wed.	9
Hillsborough	C. Frank Chunn, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	181
Indian River	William L. Fitts 3rd, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	10
Jackson-Calhoun	Jabe A. Breland, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	J. Basil Hall, Tavares	James R. Hanson, Tavares	1st Wed.	29
******Sumter*				
Lee-Charlotte-Collier-Hendry	H. Quillian Jones, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	George H. Massey, Quincy	Odis G. Kendrick Jr., Tallahassee	Quarterly	58
Madison	Wallace E. Winter, Madison	Julian M. DuRant, Madison		5
Manatee	Willett E. Wentzel, Bradenton	Marjorie L. Warner, Bradenton	2nd Tues.	25
Marion	William H. Anderson Jr., Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	30
******Levy*				
Monroe	Edward Gonzalez, Key West	Herman K. Moore, Key West	2nd Thurs.	12
Nassau	David G. Humphreys, Fernandina	John W. McClane, Fernandina	Last Fri.	11
Orange	Eugene L. Jewett, Orlando	Andrew W. Townes Jr., Orlando	3rd Wed.	183
******Osceola*				
Palm Beach	Thomas E. Daly, West Palm Beach	David A. Newman, Palm Beach	4th Mon.	134
Pasco-Hernando-Citrus	Frank Y. Robson, New Port Richey	W. Wardlaw Jones, Dade City	2nd Thurs.	18
Pinellas	Alvin L. Mills, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	217
Polk	Theodore C. Keramidas, Winter Haven	James T. Shelden, Lakeland	2nd Wed.	92
Putnam	Lawrence G. Hebel, Palatka	James A. Long Jr., Palatka	2nd Tues.	10
St. Johns	James J. DeVito, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	19
St. Lucie-Okeechobee-Martin	Laurance D. Van Tilborg, Ft. Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	21
Sarasota	Henry J. Vomacka, Sarasota	Lloyd J. Duest, Sarasota	2nd Tues.	53
Seminole	J. Clifford Boyce, Sanford	Terry Bird, Sanford	2nd Tues.	19
Suwannee	William P. Blackmon, Mayo	Hiram B. Curry, Jasper	1st Sat.	9
Taylor	George H. Warren, Perry	Walter J. Baker, Foley	Last Fri.	5
******Dixie, Lafayette*				
Volusia	Cleland D. Cochrane, Daytona Beach	Robert L. Miller, Daytona Beach	2nd Tues.	85
******Flagler*				
Walton-Okaloosa	Robert von P. Maxon, Fort Walton	Arthur G. Williams Jr., Valparaiso	3rd Thurs.	20
Washington-Holmes	Ralph H. Segrest, Bonifay	Bayllye W. Dalton, Chipley		6
				Total 2,608

**Supervise and aid until organized separately.*

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